

**Clinicians' experiences of therapeutic work in a child  
and adolescent mental health service: An  
interpretative phenomenological analysis**

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## **Declaration**

I declare that I am the sole author of this thesis and that the work contained herein is my own. This thesis, or any part of it, has not been submitted for any other degree or professional qualification.

Jessica Hendry

1<sup>st</sup> August 2008

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# Abstract

## Background

Clinical therapeutic work entails exposure to traumatic narratives and the emotional experiences of distressed clients. There is evidence that this type of work can lead to negative psychological consequences for therapists, consequences that have been variously labelled compassion fatigue (Figley, 2002), vicarious traumatisation (McCann & Pearlman, 1990) and traumatic countertransference (Neuman & Gamble, 1995). Recent investigations into the negative consequences of therapeutic work (e.g. Steed & Downing, 1998) have however reported incidental findings of positive sequelae for therapists, calling into question the conceptual sufficiency of models of fatigue and traumatisation.

The emergence of positive psychological sequelae from trauma has been investigated within clinical populations using the framework of post-traumatic growth (Tedeschi & Calhoun, 2004). A recent study (Arnold *et al.*, 2005) employing qualitative methodology was the first to investigate the possibility of post-traumatic growth occurring in therapists through vicarious contact with client's trauma. This provided preliminary evidence to suggest that models of vicarious traumatisation underestimate the positive developmental aspects of therapeutic work.

Clinical therapeutic work with children has previously been seen to be an area of high risk for therapist stress (Cunningham, 1999). Despite this, little research has investigated the specific effects of therapeutic work with children and young people.

## Method

The present study aimed to build upon the existing research by investigating clinicians' experiences of therapeutic work within a Child and Adolescent Mental Health Service, using a qualitative approach, Interpretative Phenomenological Analysis.

Eight CAMHS clinicians participated in individual semi-structured interviews, focusing on significant clinical experiences, effects of clinical experiences, perceived influence of therapeutic work and changes over time.

## Results

Five super-ordinate themes were generated from the analysis: *Client Acting Upon Therapist, The Person and The Professional, Responsibility, Support and Emotional Growth and Depletion*.

Clinicians described the varying ways in which the emotional impact of their work is felt and experienced. The emotional complexity of the work was seen to link to shifts in clinicians' parameters of responsibility and to their experience of the professional self. Both shorter term and longer term influences of the work were highlighted. For some, this included facets of experience in keeping with concepts of vicarious traumatisation and burnout, while for others there was a perceived development in emotional understanding and regulation over time.

Implications for clinical practice are drawn out, specifically suggesting the potential benefits of a greater commitment to recognising, discussing and understanding therapists' emotional reactions to the work at individual, team and organisational levels. Possible barriers to the achievement of this goal, at both individual and organisational levels are put forward.

## 1. Background to the study: a reflection

This study was informed by the researcher's own experience of and reflections upon working within a Child and Adolescent Mental Health Service (CAMHS). The background to this is as follows:

I had recently begun a placement within a CAMH service, where it seemed as though a substantial proportion of the referrals involved high levels of trauma and adversity. I was aware of my own reactions to hearing some of the material and began to wonder what the impact of this work might be on me, both in the short and longer term and whether this was work that I would be able to sustain over time. I also noted that many of the clinicians within the service had worked there for a number of years and seemed to me to be able to cope well with the work, indeed, they seemed to be thriving in the setting.

I started to wonder how the work might impact on other clinicians within the setting. How did they cope with the work, particularly over the longer term, and how might the work influence them emotionally, behaviourally and cognitively? With these thoughts in mind, I began to look at some of the existing literature around the impact of clinical work.

I conducted literature searches with terms such as *therapist*, *psychotherapist*, *psychologist* and *stress*, *occupational stress*, *well-being*, *mental health*, *impact* and variants of these terms using psychINFO, MEDLINE, EMBASE, CINAHL and Social Work Abstracts databases.

My preliminary reading of the literature around the impact of clinical work initially led me to concepts such as ‘vicarious traumatisation’ (McCann & Pearlman, 1990), ‘compassion fatigue’ (Figley, 2002) and ‘burnout’ (Farber & Heifetz, 1982).

Interestingly however, a number of studies of the negative impact of therapeutic work on clinicians (Radeke & Mahoney, 2000; Steed & Downing 1998,) reported incidental findings of positive sequelae, thus calling into question the conceptual sufficiency of models of ‘fatigue’ and ‘burden’.

The literature around ‘trauma’ and traumatisation’ provides a natural lead into the counterpart areas of ‘benefit-finding’ ‘stress related growth’ and ‘post-traumatic growth’ (PTG) (Tedeschi & Calhoun, 2004). Although the focus of this research is on clinical populations, it was interesting to note that a recent investigation (Arnold, Calhoun, Tedeschi and Cann, 2005) employing qualitative methodology had investigated the possibility of ‘post-traumatic growth’ occurring within therapists through vicarious contact with their client’s trauma.

In order to provide a framework from which to generate my research aims, these concepts are discussed in more detail in the following section.



## **2. Introduction to the literature**

### **2.1. Trauma**

The potentially devastating impact of psychological trauma first came to the fore during the First World War, when some 80,000<sup>1</sup> cases of ‘shell shock’ were reported within the British army. It was not however until the 1980s that post traumatic stress disorder (PTSD) was first formally named and recognised as an anxiety disorder within psychiatric diagnostic systems such as the Diagnostic and Statistical Manual (American Psychiatric Association, 1980).

The growing awareness and recognition within society of the occurrence and impact of sexual abuse, domestic violence and war related trauma, means that the trauma population no longer remains so hidden (Herman, 1992). In addition there is now a growing evidence base for psychological therapies for trauma (NICE, 2005), leading to a greater number of trauma survivors coming forward for psychotherapy (Pearlman & Mac Ian, 1995). The nature of these therapies involves a ‘working through’ of trauma narratives, which inevitably exposes therapists to some of the starkest and darkest details of traumatic events as well as clients’ emotional reactions to these. This places particular demands on therapists, who may be unprepared for this type of work (Pearlman & Mac Ian, 1995).

### **2.2. The challenge of therapeutic work**

Despite the theoretical and technical differences between various therapeutic approaches, it is generally agreed that the essential ingredient of therapy is the formation of a unique relationship or ‘alliance’ between therapist and client (e.g. Luborsky *et al.*, 1975).

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<sup>1</sup> Taken from [www.bbc.history.co.uk](http://www.bbc.history.co.uk)

The central role of the therapist within this relationship has been described as to 'contain' (Bion, 1962), to 'hold' and provide 'ego support' (Winnicott, 1986) to 'share the emotional burden of trauma' (Herman, 1992), to act as 'witness' (ibid), to be a 'collaborative empiricist' (Beck, 1979) or to help the client 'face uncomfortable truths' (Leiper & Maltby, 2004, p.13).

Gillrath, Shaver & Mikulincer (2005) argue that despite differences in terminology, 'compassion', where the therapist *'feel[s] with and for that person and care[s] about the suffering of that person'* (Leahy, 2005 p. 196), is the central uniting force in therapeutic encounters.

Although not all work as a therapist involves intensive trauma related work, the majority of therapists, (regardless of specialism), will be expected to engage in trauma based work within their working lives. Moreover, it is widely recognised that psychotherapy is a 'demanding profession' (Neuman & Gamble, 1995), which can leave therapists lonely, isolated, uncertain and daunted by responsibility. Figley (2002) in agreement with this, noted that: *'there is a cost to caring'* (p. 1433). These 'costs' have been captured in various ways by terms such as 'countertransference', 'secondary traumatic stress', 'compassion fatigue', 'burnout' and 'vicarious traumatisation'. Although there is considerable overlap within these constructs (Sexton, 1999), there are also theoretical differences between them. Each will therefore be examined in turn.

### **2.2.1. Aspects of countertransference**

The concept of countertransference comes from the psychoanalytic tradition and is used to refer to two different aspects of the therapeutic process (Leiper & Maltby, 2004). The first dimension of countertransference is thought to arise from the intrusion of the therapist's own unconscious needs and conflicts into the therapy session. This can significantly interfere with the process of therapy, distracting the

therapist from focusing clearly on the clients needs. This type of reaction provides the rationale for the psychodynamic therapist undergoing a lengthy personal analysis of his or her own, allowing greater awareness of his or her own unconscious needs and conflicts and thus becoming free to focus more clearly on the client's needs.

The second dimension of countertransference can be seen as a reaction to the client's 'transference', that is the client's unconscious tendency to 'transfer' aspects of past relationships onto the present therapeutic relationship. When attended to carefully by the therapist, this countertransference reaction is said to provide a valuable insight into the client's internal world. This involves the therapist's awareness of his or her reaction to the client, which can give information about the client's hidden internal world and how he or she relates to others (Leiper & Maltby, 2004).

Countertransference and transference reactions are the mainstay of the psychoanalytic tradition and are thought to be a key feature of every therapeutic relationship. Trauma focused work however, often brings a particular dimension to the countertransference response, alternately placing the therapist in the role of perpetrator, helpless witness or victim (Neuman & Gamble, 1995). It has been suggested that, in response to this role assignment, trauma therapy can lead to particular types of 'defensive countertransference' in therapists (Wilson & Lindy, 1994, cited in Sexton, 1999). Firstly, 'avoidance reactions', prompted by the therapist's experience of painful affect, can lead to denial and minimisation of the trauma, coupled with avoidance of empathic engagement with the client. Conversely, over-identification can lead to over-involvement, idealisation and a guilt induced need to 'do more' for the client.

Neuman and Gamble (1995) note that novice trauma therapists may be particularly vulnerable to these type of powerful countertransference reactions, particularly when placed in a 'perpetrator' role which is dissonant with the novice therapist's need to feel like an 'adequate', 'successful' or 'helpful' therapist. Novice therapists in

particular may have difficulty tolerating feeling ‘*helpless, shamed, attacked and abandoned*’ (ibid) all of which may be features of the emotional journey of trauma work.

### **2.2.2. Vicarious traumatisation**

McCann and Pearlman (1990) noted that: ‘*persons who work with victims may experience profound psychological effects that can be disruptive and painful for the helper and can persist for months or years after work with traumatised persons*’ (p.133) The term they coined to describe these effects is ‘vicarious traumatisation’.

McCann and Pearlman’s concept of vicarious traumatisation is rooted within a constructivist self-development theoretical framework, which construes it as being the consequence of an interaction between the therapist’s worldview and the emotional impact of the trauma narrative. According to this theory, changes in the therapist’s psychological world come about through repeated ‘*exposure to emotionally shocking images of horror and suffering*’ (McCann & Pearlman, 1990, p.134). As a result of this exposure and, crucially, of engaging empathically with the client, a process of change within the therapist’s cognitive schemas and memory systems is said to ensue. Such changes can challenge beliefs about the benevolence of others, the safety of the world and the security of family life in particular (Cunningham 1999). Importantly, such effects are thought to be pervasive, cumulative over time and permanent. This can be contrasted with the client-specific, short-term nature of the countertransference reaction.

The concept of vicarious traumatisation provides a normative model for therapists’ reactions to trauma, with an expectation that all trauma therapists will experience enduring alterations in their cognitive schemas. The degree to which a therapist is affected by the traumatic material is thought to relate to the salience of particular cognitive schemas about trust, safety, control, esteem and intimacy to individual

therapists, as well as situational aspects of the work setting (McCann & Pearlman, 1990).

Evidence to support the contributions of both situational and individual factors to vicarious traumatisation has yielded somewhat conflicting and inconclusive results, perhaps indicating that these factors may interact in complex ways. One important variable in considering the impact of therapeutic work on clinicians is that of clinicians' personal trauma history. Previous research has indicated that up to one third of clinical and counselling psychologists report having been sexually or physically abused as a child or adolescent, most often by a relative (Pope & Feldman-Summers, 1992). This figure is supported by similar studies into this area (Brady, Guy, Poelstra & Brokaw, 1999; Schauben & Frazier 1995). Evidence of the impact of personal trauma history on therapist coping is however contradictory, with some studies reporting increased risk amongst those with a personal trauma history, while other studies (e.g. Schauben & Frazier, 1995) have not supported this finding.

Schauben and Frazier (1995), used questionnaires to investigate the emotional and cognitive effects (at the level of schemas) of working with (adult) sexual violence survivors. Among the sample of 148 female counsellors, significant positive correlations were found between working with a higher percentage of sexual violence survivors and greater disruption in schemas about self and others, higher levels of PTSD symptoms and higher levels of self-reported vicarious trauma. Interestingly, this study also reported that counsellors with a personal history of sexual victimisation were not more distressed by their work than counsellors without this history.

In contrast to this, Pearlman and Mac Ian (1995), examined levels of vicarious traumatisation in 188 self-identified trauma therapists. They found that novice therapists and those with a personal trauma history were most at risk of negative effects of the work, as measured by the Symptom Checklist\_90\_Revised (SCL-90-R;



Derogatis, 1977), the Traumatic Stress Institute Belief Scale (TSI Belief Scale; Pearlman 1995) and the Impact of Event Scale (IES; Horowitz, Wilner & Alvarez, 1980). Overall however, levels of disruption as measured by the TSI were lower than in previous studies, suggesting that despite their work, most therapists seemed to be coping well.

Brady *et al.*, (1999) assessed disruptions in cognitive schemas and PTSD symptoms in a sample of 1,000 female psychotherapists working with sexual abuse survivors. They found that therapists with higher levels of exposure to trauma reported more trauma symptoms on the Impact of Events Scale but did not show significant disruption of cognitive schemas. The authors conclude that long-term disruptions to cognitive schemas and beliefs are not likely to result from this work.

While vicarious traumatisation seems to have gained acceptance as a valid construct (Jenkins & Baird, 2002), studies investigating the prevalence of vicarious traumatisation seem to indicate that it is not endemic within trauma work. This may be a reflection of a number of methodological disparities within the research, as well as a lack of empirical investigation into the construct (Dunkley & Whelan, 2006). For example, many of the therapist participants within the existing literature work within private practice (predominantly in the United States), a setting that Pearlman and Mac Ian (1995) indicated is a protective factor compared to hospital and clinic settings. There also tends to be poor specification of the types of 'trauma' work undertaken and levels of exposure to his work. Further work is therefore needed to understand the complexities and limitations of the construct, particularly with regard to working with specific clinical populations (Dunkley & Whelan, 2006).

### **2.2.3. Secondary traumatic stress and compassion fatigue**

Secondary traumatic stress (STS) refers to the experiencing of emotional distress in a person (usually a helper or caregiver) as a result of close contact with a trauma survivor (Figley, 2002). Such distress closely resembles the symptoms of PTSD and

may involve elements of re-experiencing the survivor's traumatic event, avoidance of reminders and persistent arousal associated with the client. Secondary traumatic stress was later reconceptualised as 'compassion fatigue', a term which was thought to be less stigmatising to clinicians. Figley (2002) argues that compassion fatigue, which has a sudden and acute onset, is a 'natural consequence' of empathic engagement with traumatised clients and represents a unique form of caregiver burnout, reducing therapist interest in bearing others' suffering.

Figley (2002) provides a causal model for the prediction of compassion fatigue, suggesting that factors such as empathic concern, sense of achievement, ability to disengage (seen as a conscious protective strategy between sessions), length of exposure, therapist life disruptions and traumatic recollections of client material all contribute to the emergence of compassion fatigue. Importantly this model also suggests that the effects of compassion fatigue can be mitigated by understanding and intervening in the causal pathways.

The most widely used measure of compassion fatigue is Figley's (1995) 'Compassion Fatigue Self-Test for Practitioners' (CFST), which measures both compassion fatigue and burnout. In an empirical investigation of levels of compassion fatigue within a sample of mental health workers, 37 percent of respondents were reported to be at high-risk of compassion fatigue, while 54 percent were at a high risk of burnout (Rudolph, Stamm & Stamm 1997). These figures are fairly consistent with findings from other research in this area (Figley, 2002). Figley therefore highlights the widespread nature of emotional distress amongst therapists and argues that mental health care providers have an ethical obligation to raise awareness of the risks of compassion fatigue and to provide organisational structures to support those who are affected by their work.



### **2.2.4. Burnout**

Burnout has been described as: *‘the psychological strain of working with difficult populations’* (McCann & Pearlman, 1990, p.133) or, more fully, as: *‘a defensive response to prolonged occupational exposure to demanding interpersonal situations that produce psychological strain and provide inadequate support’* (Jenkins & Baird, 2002, p. 424) Burnout as a concept is therefore not unique to therapeutic work and may be seen to result from any number of demanding professions involving working with people, often as a result of lack of support within organisational structures.

Maslach (1982) has described ‘emotional overload’ and ‘emotional exhaustion’ as being a key part of the ‘burnout syndrome’. Maslach and Jackson’s Burnout Inventory (Maslach & Jackson, 1981) contains subscales of emotional exhaustion, depersonalisation and (reduced) personal accomplishment. High scores on these scales may reflect feelings of reduced competence and achievement, apathy, cynicism and detachment.

Azar (2000) lists symptoms of burnout within cognitive, emotional and behavioural domains. For example, being quickly provoked to anger, tears and irritation, inflexible thinking, reduced sociability, increased risk taking, substance abuse, cynicism and living to work are amongst the many and varied symptoms.

To date, there has been limited investigation into specific aspects of burnout in psychologists or psychotherapists (Rupert & Morgan, 2005). Moreover, existing research provides conflicting reports about the contributions of age, caseload and experience (Rupert & Morgan, 2005). One consistent finding however is that independent practitioners report less burnout than those working in agency settings (Rupert and Morgan, 2005), a finding that has been attributed to lower control over workload and greater disturbance amongst clients using agency settings.

Child Protection Work has been seen to be an area of high risk for burnout. A recent study by Bennett, Plint and Clifford (2008) found evidence of burnout in one third of hospital-based child protection workers, with two thirds of workers indicating they had considered leaving the work. This finding suggests that burnout is a particular risk for workers in this setting and highlights the need for proactive strategies to prevent workforce attrition.

### **2.3. *Impact of working with children***

Azar (2000) suggests that clinical work with children and families poses special risk for burnout. She suggests that this is due to specific aspects of child and family work, including the 'multi-stressed' nature of families seen in abuse cases, conflicts of needs within family systems, parental non-compliance or premature withdrawal of the child from therapy, the discovery of ongoing abuse, the undervaluing of 'child based' work in society and clinician's helplessness in protecting the child from inadequate care. The suggestion is that the impact of burnout can lead to over-identification with children or parents, becoming a 'trauma junkie' (seeking out the most challenging cases) and affective dysregulation, which is often played out within working relationships.

Despite these assertions however, there is very little empirical research into the specific effects of working therapeutically with children and young people.

In one study, Dyregov and Mitchell (1992) used a quantitative questionnaire based design to investigate the reactions and coping responses of emergency personnel involved in rescuing children following a bus disaster. The findings of this study suggested that working with children in this capacity leads to a '*breakdown of natural defences*' and a strong sense of '*identification with the victim*' (p. 5). Coping strategies commonly used by emergency personnel included 'suppression of emotions', 'distancing' and 'dehumanising'.

Although this study has been cited within the therapeutic literature base (Dunkley & Whelan, 2006), working with children in acutely traumatic settings such as rescue work is evidently different to engaging in therapeutic work with children, where exposure to traumatic material is likely to be second-hand, through clients' trauma narratives. In therapeutic settings coping strategies such as 'distancing' and 'dehumanising' are unlikely to be available to the empathically engaged therapist, whose task is to 'bear witness' (Herman, 1992) and help make sense of the experience.

In relation to therapeutic work with children, Cunningham (1999) discusses the theoretical impact of work with sexually abused children and adolescents on the clinician. The author hypothesises that a particular type of 'grief process' can occur within vicariously traumatised clinicians working with this population as a result of challenges to schemas regarding family life. Such a process may be characterised by stages of denial, anger, sadness, depression and resolution. According to this author, child abuse work is said to be particularly stigmatising, leaving clinicians isolated and unable to share the burden of their experience. This is said to place these clinicians at particular risk.

In contrast to this however, the findings of Brady and Guy's (1999) questionnaire based study, suggested that therapists treating child and adolescent sexual abuse were no more at risk of experiencing vicarious traumatisation than therapists treating adult sexual abuse survivors. The authors hypothesise that this may be because much abuse-focused work with adults involves working through childhood sexual abuse and therefore exposes therapists to similar types of trauma material as child-based work.

Marriage and Marriage (2005), using a semi-structured interview format, investigated the responses of child and family mental health workers to stressors within their jobs, and the coping strategies they employed to deal with these. This

indicated that all participants evidenced aspects of an 'altered worldview', thought to be a hallmark of vicarious traumatisation, within accounts of their work. However, there was no evidence of burnout or secondary traumatic stress in any of the participants. While this may suggest the possibility of higher levels of vicarious traumatisation within child and family workers compared with homogenous samples of 'trauma' therapists, such as those studied by Pearlman and Mac Ian (1990), such a finding may also be a reflection of the differential sensitivity of qualitative research to complex constructs such as vicarious traumatisation. This suggests the importance of a combination of both qualitative and quantitative methods in this research area.

In another qualitative study, Affleck (2005) investigated the experiences of therapists working within child sexual abuse teams in Scotland. This found that there is a 'strong emotional impact' to this type of therapeutic work with children, which may be understood within a psychodynamic framework incorporating concepts of transference, countertransference and projective identification. Interestingly however, therapists reported noticing that their emotional reactions to the work had changed over time, in that they had become 'desensitised' to it. Affleck emphasises the importance of understanding such processes of change in response to therapeutic work and suggests that this would be a fruitful area for further research.

#### **2.4. *The other side of the coin***

The idea that growth and strength may come from suffering has a long history. Adages such as 'no pain, no gain' and 'that which doesn't kill us makes us stronger' (Neitzsche) are enshrined within folk psychology. Indeed, many religious and philosophical schools of thought promote the view that suffering can lead to spiritual reward and enlightenment.

Even within academic psychology, this view is promulgated. Victor Frankl, psychiatrist and pioneer of 'Logotherapy', was himself a survivor of the Auschwitz concentration camp. Writing in 'Man's Search for Meaning' he suggests that:

Clinicians' experiences of therapeutic work

*'We must never forget that we may also find meaning in life even when confronted by a hopeless situation. For what then matters is to bear witness to the uniquely human potential at its best, which is to transform a personal tragedy into a triumph, to turn one's predicament into a human achievement. When we are no longer able to change a situation... we are challenged to change ourselves' (p. 116)*

Similarly, Carl Rogers (1961), in describing the characteristics of a helping relationship, suggests that:

*'If I am to facilitate [as a therapist] the personal growth of others in relation to me, then I must grow, and while this is often painful it is also enriching'. (p. 51).*

Despite the potential negative and distressing impact of therapeutic work, the fact that many therapists persist in working in the field suggests that such negative effects are not pervasive. Indeed, a number of researchers have drawn attention to the fact that many therapists also report that their work has affected them in positive ways (Brady & Guy, 1991 McCann & Pearlman, 1990). There is a tendency however for these aspects to be reported as 'incidental' findings within largely quantitative investigations of vicarious traumatisation, with little follow-up on the significance of these findings.

For example, McCann and Pearlman (1990), anecdotally acknowledge that despite facing vicarious traumatisation, therapists may be '*sadder but wiser*'. They suggest that the work can '*enrich our lives in countless ways*' and that '*there are many personal rewards inherent in this work*' (p 147).

Brady and Guy (1991), in an investigation of levels of vicarious traumatisation, found that clinicians who saw more sexual abuse survivors reported greater



existential and spiritual satisfaction (as measured by the Spiritual Well-being Scale; Ellison, 1983) than those with less exposure to this clinical population. They hypothesise that working with sexual abuse survivors might serve as a '*catalyst for therapists' personal growth*' (p.392). Similarly, Sexton (1999), in a review of the literature on vicarious traumatisation of therapists, suggests that trauma work offers '*inherent rewards*', potentially inspiring '*a deepening in personal growth in the therapist*' and the discovery of a '*deeper humanity*' (p.401).

Radeke and Mahoney (2000) carried out a quantitative study into perceived effects of work on therapists' lives. Questionnaire responses indicated that although therapists reported statistically significantly higher levels of emotional exhaustion, anxiety and depression than a comparison sample of research psychologists, they also reported a greater sense that their work had influenced them in positive ways. The authors conclude that therapists as well as clients may be changed in positive ways by psychotherapy, and that although therapeutic work can be emotionally stressful, it can also be personally enriching in complex ways. They suggest that practitioners may be rich sources of information about the processes of human change and adaptation and that this would be a fertile area for future research.

Kramen-Kahn and Hansen (1998) conducted a survey to identify occupational hazards, rewards and coping strategies amongst therapists. Results indicated that the most frequently endorsed sources of occupational reward included opportunities for growth both in the client and therapist, particularly for female therapists (an unexpected finding which the authors tentatively suggest may indicate that females derive greater satisfaction from the 'relational' facet of the occupation). They also noted that more experienced therapists reported fewer occupational hazards than less experienced therapists. They postulate that this may reflect an effect of habituation over time to the stresses of the profession, or to the operation of more mature defences, such as humour, within more experienced therapists.

## Qualitative Studies

Dlugos and Friedlander (2001) interviewed a select sample of twelve peer-nominated 'passionately committed' psychotherapists to gain an understanding of how these therapists sustain careers in this area. Four core themes emerged from the analysis representing 'balance' (e.g. within work caseload and also between work and personal life), 'adaptiveness/openness' (e.g. meeting obstacles as challenges), 'transcendence/humility' (e.g. acknowledgement of the spiritual dimension of being a therapist) and 'intentional learning' (e.g. being able to learn about themselves and other people in a way perceived to be enriching).

Steed and Downing (1998) carried out a phenomenological study of vicarious traumatisation within therapists working with adult sexual abuse survivors. While there was evidence of therapists experiencing pervasive negative effects of the work, many positive sequelae of the work were also noted. This included instances of therapists' reporting greater '*depth of compassion*' (p.5), increased positive self-identity and a greater appreciation of client's strength and resilience. These findings led the authors to suggest that the current conceptualisation of vicarious traumatisation may be limited and that investigation into the potential positive effects of trauma therapy would enhance understanding of the phenomenon.

There is a tendency for research to focus on the detrimental aspects of therapeutic work, perhaps reflecting the dominance of models of pathology and deficit within academic psychology. Aspects of growth and positive sequelae therefore tend to emerge as epi-phenomena within deficit focused models, which tend to preclude the possibility of concurrent growth and distress.

### **2.4.1. Posttraumatic growth**

The phenomenon of growth and positive sequelae arising through suffering and trauma has attracted increasing interest in academic fields of psychology over recent years (Zoellner & Maercker, 2006). Although this phenomenon has been referred to



as ‘benefit-finding’, ‘stress-related growth’ and post-traumatic growth’, (Tedeschi & Calhoun, 1995), there has been a flourishing interest in the concept of posttraumatic growth in particular.

Posttraumatic growth (PTG) has been defined as ‘*a subjective experience of positive psychological change reported by an individual as result of the struggle with trauma*’. (Zoellner & Maercker, 2006, p. 628). Within this model, ‘trauma’ is more broadly conceptualised than within the DSM definition, encompassing events such as cancer diagnosis and treatment or the traumatic death of a relative. The term ‘growth’ within the model emphasises a change in psychological functioning that indicates an advance beyond the person’s previous levels of functioning. Posttraumatic growth therefore goes beyond a state of mere ‘recovery’ after trauma, which would be more akin to the concept of ‘resilience’.

Tedeschi and Calhoun’s (2004) model of posttraumatic growth draws upon Jannoff-Bulman’s (1992) theory of shattered assumptions in order to conceptualise the notion of growth. They suggest that a traumatic event of ‘seismic’ proportions shakes or destroys key elements of a person’s beliefs and worldviews (Zoellner & Maercker, 2006). This seismic event is postulated to challenge the person’s ability to manage their resultant emotional distress, resulting in a process of rumination and attempts to eliminate the distress. Following a period of initial ‘automatic’ rumination, which may be characterised by an ‘intrusive’ type of thinking, a ‘constructive’, more deliberate version of cognitive processing is said to ensue. This ‘constructive’ rumination is hypothesised to play a key role in the development of personal growth.

Tedeschi and Calhoun (2004) indicate that PTG may lead to positive changes in six key areas. This may result in:

- Increased appreciation of life
- Setting of new priorities

- Sense of increased personal strength
- Identification of new possibilities
- Improved closeness of intimate relationships
- Positive spiritual change

Despite the emerging interest in this area, there remains controversy in the literature as to whether post-traumatic growth has any adaptive significance. Studies to date have revealed no consistent relationship between measures of general distress and posttraumatic growth, although there is some evidence that posttraumatic growth may be negatively correlated with depression (Zoellner & Maercker 2006). This lack of consistency in findings may be a reflection of the diverse nature of the studies in this area, many of which have used poorly validated measures of growth in cross-sectional rather than longitudinal designs. Moreover, the 'traumatic' events range from bone-marrow transplantation (Curbow *et al.*, 1993, cited in Zoellner & Maercker, 2006) to war combat (Aldwin *et al.*, 1994, reviewed in Zoellner & Maercker, 2006). This poses a problem for the research as some have suggested (e.g. Powell *et al.*, 2003) that there may be an inverted- U relationship between the perception of posttraumatic growth and the severity of the traumatic event, with the highest growth seen following situations of medium stress. Moreover, there is a suggestion that growth and loss may be compatible (Harvey, Barnett & Overstreet, 2000) and may interact in complex ways, such that the relationship between growth and distress may shift over time.

Maercker and Zoellner (2004) propose a model of posttraumatic growth which may go some way towards explaining the inconsistent findings with regard to the adaptive significance of self-perceived posttraumatic growth. Their 'Janus face model' proposes that there are two components or sides to post traumatic growth, one that is a functional, constructive side and one that is an illusory, self-deceptive side. According to this model, self-perceived posttraumatic growth might in some instances represent a type of cognitive avoidance strategy which serves to deny

emotional distress and may highlight a dysfunctional coping strategy or at best a short-term coping strategy. This can be contrasted to the constructive component of post-traumatic growth, which is hypothesised to grow over time and should correlate positively with measures of adjustment and psychological well-being. They conclude that it has not yet been convincingly demonstrated that posttraumatic growth is a positive, adaptive phenomenon. These authors suggest that researchers must be open to allowing adaptive as well as maladaptive aspects of posttraumatic growth to be studied within research and that qualitative approaches may be of unique value in elucidating these facets.

Cheng, Wong and Tsang (2006) investigated perceived benefits and costs after the Severe Acute Respiratory Syndrome (SARS) outbreak in Hong Kong in 2003. Their results suggested that those participants who reported only benefits after the event also scored higher on defensiveness. Only those participants who reported both benefits and costs to the outbreak reported gains in personal and social resources in the eighteen months following the event. The authors suggest that individuals need to allow themselves to experience painful thoughts and feelings in order for successful adaptation to stress to occur. The suggestion is that those who experience true growth as opposed to an 'illusory' or 'defensive' perceived growth are those who are able to report both the benefits and costs of their experiences and thus in some sense have been able to work through or resolve some of the costs.

The growing interest in this field seems to fit with a wider paradigm shift from a focus on deficits and symptoms to a focus on personal meaning and strength in therapeutic models (Pearlman & Saakvitne, 1995 p.337). This paradigm shift can be seen in, for example, a shift in thinking about psychotic experiences (British Psychological Society, June 2000) where the medical model of understanding is challenged by a psychological meaning-making approach.

### **2.4.2. Posttraumatic growth within therapists**

Arnold, Calhoun, Tedeschi & Cann (2005) claim to have carried out the first qualitative study to investigate the positive consequences of working with trauma survivors. A sample of twenty one adult therapists were interviewed about their responses to working with clients who had experienced traumatic events, specifically in terms of schema disruption and perceived growth. All clinicians interviewed reported positive consequences as well as negative disruptions of the work. The authors suggest that the positive consequences of trauma work may have been underestimated in the literature and that further investigation of this area would be warranted. The authors tentatively suggest that the current model of posttraumatic growth may also be applicable to those, such as therapists, who experience trauma ‘vicariously’ but that there may also be certain types of growth that are specifically linked to the therapeutic role.

### **2.4.3. Wisdom**

Wisdom has been considered to be a ‘positive goal of adulthood’ (Smith, Staudinger & Baltes, 1994, p. 989) and has been operationalised as ‘*high-level or expert knowledge in the fundamental pragmatics of life*’ (Smith *et al.*, 1994, p. 989). The five dimensions of wisdom-related knowledge are proposed to cover: factual knowledge, procedural knowledge, life-span contextualism, value relativism and tolerance of uncertainty.

Linley (2003), posited that evidence of positive adaptation to trauma can be usefully conceptualized within a wisdom framework. Although the concept of wisdom is not restricted to situations of trauma (rather it is thought to be a lifespan developmental task), Linley (2003) suggests that wisdom may be an outcome of trauma, whereby the shattering impact of trauma paves the way for ‘*regeneration through and towards wisdom*’ (p. 603).

Baltes (1987) suggested that non-normative life events could be facilitative of wisdom. Smith, Staudinger and Baltes (1994) hypothesised that certain occupational settings may facilitate access to wisdom. In order to investigate this they carried out a study to determine whether clinical psychologists show evidence of wisdom on a life-planning task, as compared to a control sample of professionals. Their results indicated that clinical psychologists scored higher overall on all criteria of wisdom related knowledge than the control sample, suggesting the possibility that aspects of the role may help therapists acquire wisdom related knowledge.

### **3. Forming the research question**

The literature on vicarious traumatisation, compassion fatigue and burnout has shown that therapeutic work can impact on therapists in negative ways and that trauma therapists may be particularly at risk from many of these negative effects (McCann & Pearlman, 1990).

Evidence suggests that the therapeutic relationship can be adversely affected when therapists are struggling with these effects (Collins & Long, 2003), leading to unhelpful coping strategies such as avoidance, numbing, detachment or over-identification. At best these strategies can render therapists less effective in their work and at worst may compromise the client's safety (ibid). Many researchers have pointed out that recognising these effects and taking care of therapists' well-being is thus an ethical imperative both for therapists and for the organisations that employ them (e.g. Rudolph, Stamm & Stamm, 1997). Indeed, Moylan (1994, cited in Sexton, 1999, p.398) warns that unrecognised vicarious traumatisation can have a '*depressing effect*' on organisations and can lead to a state of '*organisational pathology*', (p. 398) which places further strain on therapists. The danger is that ongoing stresses of this nature can lead to a state of 'burnout' (McCann & Pearlman, 1990).



There is some suggestion that novice therapists may be particularly at risk from the stresses of therapeutic work (Neuman & Gamble, 1995; Pearlman & MacLan, 1995), suggesting the possibility that developmental processes in therapeutic work might buffer against stress (Kramen-Kahn & Hansen, 1998). It seems likely that personal variables interact in complex ways within the work, suggesting that idiographic approaches may be of unique value in understanding the nuances of such experiences.

Despite the potential and perhaps inevitable stresses of therapeutic work, many therapists remain committed to their work and appear to continue to function well psychologically (Pearlman & Mac Ian, 1995). The factors that allow for continued well-being are hypothesised to be many and varied, including personality factors such as openness and optimism, hardiness (King *et al.*, 1998) and contextual aspects of the work situation. The concept of growth from therapeutic work, however, goes beyond the notion of resilience or the ability of therapists to resist and ‘bounce back’ from the stresses inherent in the work. Although largely anecdotal or reported as unexpected and ‘incidental’ findings, there is an emerging interest in the idea of therapist’s obtaining personal growth as a result of their work. Research in this area has the potential to enrich and elucidate current conceptualisations of how therapists are affected by their work and our understanding of change processes (Radeke & Mahoney, 2000).

### **3.1. Importance of the research**

CAMHS work has previously been seen to be a ‘high-risk’ area for stress and burnout (Cunningham 1999). Despite this there is little research into how clinicians within this setting experience and are affected by their therapeutic role.

Clinicians have been said to be the most important ‘tool’ in therapy and it is widely acknowledged that ‘therapist factors’ have an important impact on therapeutic outcomes (Luborsky, 1975). It therefore seems of paramount importance to

understand the various ways that therapists are affected by their work, effects which may be carried through to clients in the course of therapeutic work.

Widening the research base in order to allow for the potential emergence of aspects of both positive and negative psychological change through clinical work will enhance understanding of the impact of clinical work. Greater understanding of the ways in which clinicians experience and make sense of their work may provide insight into ways of promoting well-being within clinical staff and of minimizing the potential impact of stress and trauma. Inquiry of this nature lends itself particularly well to qualitative research methods.

### **3.2. Research aims**

Having read the literature around these interrelated concepts in order to formulate the research aims and methodology, it was necessary to set aside or 'bracket' this knowledge in order to arrive at a fresh research position, unencumbered by *a priori* hypotheses. The research aim was therefore broadly conceptualized as follows:

The purpose of the study was to explore clinicians' experiences of therapeutic work within a Child and Adolescent Mental Health Service (CAMHS)

- To tentatively explore elements of growth and change (whether construed as beneficial or destructive) within clinicians' stories.



## 4. Method

### 4.1. Design

A qualitative design using Interpretative Phenomenological Analysis (IPA) (Smith, 1996) was chosen.

The focus of phenomenological research is on the experience of the individual human being within a particular context and time (Willig, 2001). It is a highly idiographic approach, which does not attempt to make generalized assumptions or claims about an experience. Instead the aim is to distill the core components of an experience, which may serve to highlight common meanings that can transfer from one situation to another, or from one person to another (Holloway & Todnes, 2003). IPA draws on the principles of phenomenology and hermeneutics (Smith, 2004). Phenomenology as a philosophical concept is concerned with '*the study of human experience and the way in which things are perceived as they appear to consciousness*' (Langdrige, 2007, p. 10), while hermeneutics is concerned with the way we interpret and make sense of our experiences. IPA is said to employ a 'double hermeneutic' (Smith, 2004), thus the researcher is employed in making sense of the participants' attempts to make sense of their personal and social world. Larkin (2006) emphasizes that the first aim of IPA is to understand the participant's world and describe it, while the second aim is to locate the research within a wider context and ask "*what it means*" (p. 104). Within IPA the researcher therefore has an acknowledged role in interpreting and asking questions of the data and being reflexively aware of his or her own influence in shaping the research process. It is this inquiring and creative stance that allows IPA to '*move beyond the text to a more interpretative and psychological level*' (Smith, 2004, p. 44).

IPA was chosen as an approach to this study for a number of reasons. Firstly, IPA is said to be an especially pertinent approach when research is concerned with complexity, process or novelty (Smith & Osborn, 2003). It is also said to be a truly 'psychological' approach (Willig, 2001), which values the 'voice and perspective'

(Larkin 2006) of the individual in his or her own right. The researcher was keen from the outset to be able to preserve the individual 'voice' within the study, something that is lost within nomothetic approaches which partial out such variables. IPA overtly recognizes the impact of the researcher's own experience on the interpretative process and, while this can complicate the process, it can also allow for a level of engagement with the data which can ultimately enrich the interpretative process. This stance seemed particularly suited to investigating a phenomenon of which the researcher has experience.

#### **4.2. Sampling**

Consonant with an IPA approach, purposive sampling was used to identify a group of CAMHS clinicians working within a generic 'tier three'<sup>2</sup> CAMH service, serving a population of 0-16 year olds and their families.

Although CAMHS clinicians within the service come from a variety of clinical backgrounds and training, all clinicians carry a broadly similar case load and are expected to work with a full range of clinical presentations, including cases which feature abuse and trauma. Homogeneity of the sample was therefore achieved through participants' exposure to particular types of clinical work, rather than through professional title or training.

At the outset of the research, required sample size was estimated as being between eight to ten participants. This estimation was based on sample size information given by the key proponents of IPA (Smith 2004, Smith & Osborn 2003), who indicate that IPA studies typically have smaller sample sizes due to the in-depth analysis required for a high quality IPA project. Harper (2007) cautions that in time restricted research projects typical of clinical psychology doctorates, large sample sizes can lead to

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<sup>2</sup> 'Tier three' services, according to the NHS Health Advisory Service (1995) report 'Together we stand', are multidisciplinary specialised outpatient services for children with more severe, complex and persistent disorders.

superficial analysis. There is however, no 'right answer' (Smith & Osborn 2003) when it comes to sample size for an IPA study and the final sample size was therefore determined by both practical constraints and the perceived level of richness of the data generated.

### **4.3. Recruitment**

Clinicians working within five small geographically dispersed CAMHS teams serving a single health board were approached via their weekly team meetings and invited to take part in the study. Information sheets (see appendix one) about the study were handed out to team members, who were given time to consider whether they wished to be involved in the study. Potential participants were asked to contact the researcher by phone or e-mail to register interest in taking part. All participants were given the opportunity to ask questions before taking part in the research.

#### **4.3.1. Participants**

A total of ten female clinicians volunteered to take part in the study. This represents an approximate thirty percent response rate. Participants came from four of the five CAMHS teams serving the health board, which covers both rural and urban areas. Length of CAMH service ranged from three<sup>3</sup> to twenty-two years. Participants came from diverse original training backgrounds including psychiatry [n=1], nursing [n=1], social work [n=5] and occupational therapy [n=1]. However all participants were now working as child and adolescent mental health workers, carrying out therapeutic interventions with children, young people and families. Participants cited their predominant therapeutic models as being systemic [n= 5], psychodynamic

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<sup>3</sup> These figures reflect the number of years spent working within child and adolescent mental health services. It should be noted however that many of the participants had previous professional experience of working in other settings such as social work child and family teams and adult mental health services.

[n=7], behavioural/cognitive behavioural [n=4], solution focused [n=1] and 'eclectic'[n=1].

#### **4.4. Data Collection**

Semi-structured interviews were chosen as the method of data collection. These are generally considered to be the method of choice for an IPA approach as they allow for detailed articulation of the individual's experience (Langdridge, 2007).

##### **4.4.1. Development of the interview guide**

The final interview guide (see appendix two) consisted of four core questions, covering significant clinical experiences, effects of these, perceived influence of therapeutic work and changes over time. As is recommended by Smith and Osborn (2003), these were designed to be broad, open-ended questions, which would allow the participant to explore in detail their experiences of therapeutic work.

##### **4.4.2. Pilot Interviews**

A pilot interview was conducted in order to practice interview technique and to reflect on the wording and sequence of the interview questions. The pilot participant was also asked for feedback regarding the interview experience. The pilot interview data was not used in the analysis.

Following reflection on the course of the initial two interviews, the number of questions in the interview schedule was reduced and the wording of the questions was improved for clarity (see appendix two). Consequently two interviews were omitted from the analysis in order to maintain consistency within the interview process. The original interview schedule can be seen in appendix three. The final sample for analysis consisted of eight participants.

#### **4.4.3. Interview Process**

Semi-structured interviews were carried out between December 2007 and March 2008. All interviews were carried out in private clinical rooms within the CAMH service. Interview durations ranged from 58 minutes to 80 minutes. All interviews were recorded using a Sony IC Digital Recorder (ICD-SX20).

Each interview began by asking the participant if they had any questions about the interview process or research before commencing. Once any questions had been satisfactorily answered, participants were asked to sign a consent form (see appendix four). A brief introduction was then given to the interview (see appendix two).

Participants were then asked a few questions about their job title, training route and interest in particular therapeutic models/theories. These introductory questions were intended as an 'icebreaker' in order to ease participants into the interview process.

Probes were used to assist participants to follow up on their accounts or to clarify meaning where necessary. Probes were also designed to be as neutral and non-leading as possible, for example: 'can you tell me more about that?' or 'what about that stands out for you?'

The researcher monitored the effect of the interview on the respondents throughout the interview process, in particular being aware of any signs of discomfort or distress.

Interviews continued until the point where it seemed that participants were either unable to expand further on their accounts or where the researcher sensed fatigue within the participant. At the end of the interview the participants were thanked for their time and contribution and were given time to reflect on the interview with the researcher. All participants were asked the question: 'is there anything else that you wanted to mention today that you didn't get chance to talk about?' This was designed



to allow participants to bring up any previously unmentioned issues and to comment on how the interview might have differed from their expectations.

#### **4.5. Data Management**

Following each interview the digital recording was saved onto a secure computer. The original file was then erased from the digital recorder.

The digital recordings were transcribed verbatim by the researcher. Transcription was at a semantic level and included some discursive features such as, pauses, stutters, repetitions, laughs and sighs (see appendix five for transcription notation). Prosodic features were not recorded in the transcription, as this level of detail is generally not considered necessary within an IPA study (Smith & Osborn, 2003). Once checked for accuracy, the transcripts were imported into the NVivo 7 software management package for qualitative data (QSR NVivo 7).

##### **4.5.1. Analysis of data**

Although the analytic method within IPA is not prescriptive and allows for creativity within the process of analysis (Smith, Jarman & Osborn 1999), the researcher favoured the individual approach to analysis of transcripts, as outlined by Smith, Jarman and Osborn (1999) as a methodological guide. Within this approach, individual transcripts are treated as individual case studies, with the same analytical steps applied to each transcript in turn. Commonalities are only sought after a thematic structure has been generated for each transcript individually. This approach allows for the researcher to preserve the unique features of each individual account and also means that equal importance is given to themes emerging from later transcripts as to those emerging from earlier transcripts. Smith, Jarman and Osborn (1999) suggest that this approach works best for smaller studies of up to around ten participants.



The process of analysis followed is described step by step below:

- 1). The first transcript was read and reread in order to gain familiarity with the interview as a whole. Following on from this, the right hand margin was systematically used to note down anything within the text that seemed significant or interesting. Smith, Jarman and Osborn (1999) suggest that these notes may reflect *'associations or connections that come to mind'* (p.220), they may be attempts to summarise parts of text or they may involve preliminary interpretations. This process was followed for the entire text.
- 2). Returning to the beginning of the first account, the margin of the transcript was used to write down emerging themes at a more abstract level. At this point there was an attempt to generate 'key words' to capture the concepts that had been highlighted previously. This process was continued for the entire transcript.
- 3). After this initial manual work, Nvivo computer software was used as an aid to generating and editing a list of emerging themes from the first transcript. Connections between themes were sought. For example, themes were examined to see if any of them appeared to 'cluster' together, or whether they seemed to share meaning or links and whether they seemed to relate to other themes in a super-ordinate way. Throughout this stage the researcher referred to the original text to ensure that connections still made sense in relation to the original text.
- 4). At this stage the themes were arranged into a 'master' summary of themes, which seemed to most accurately represent the participant's account. Themes were linked to examples within the text to ensure accurate representation of the raw data. In this way the researcher moved between the text and the emerging themes in an iterative, cyclical way.
- 5). This cyclical process of analysis was repeated for each transcript, generating a summary of themes for each interview.

6). At the integrative stage of analysis, summary themes for each interview were reviewed for instances of commonality and difference. A process of clustering the themes together into common super-ordinate and subordinate themes occurred, again checking back to the original data to ensure representation. Finally, a list of master themes, which seemed to best capture the essential qualities of the participants' shared experiences, was generated. One participant's account, which notably did not 'fit' with some of the integrative master themes but which nevertheless provided rich data, was retained for separate comment.

#### **4.6. *Quality of the research***

The traditional frameworks of 'validity' and 'reliability' arise from a positivist quantitative research paradigm (Smith, 2003) and have therefore been seen to be inappropriate for evaluating qualitative research.

While quantitative research may be concerned with 'truth-seeking' (Cho & Trent, 2006), qualitative research paradigms acknowledge the existence of 'multiple constructed realities' where there may be no 'single tangible reality' (Lincoln & Guba, 1985). The central interpretative role of the researcher in approaches such as IPA does, however, necessitate ways of ensuring credibility within qualitative research design. Indeed, any research, whether qualitative or quantitative, must be answerable to critical questions (Silverman, 2006).

In response to the growing popularity of qualitative research methods within psychological research, several guidelines for assessing quality within qualitative research have been distilled from the existing literature (Elliot, Fischer & Rennie, 1989; Yardley, 2000). While there are many criteria common to all of these guidelines, Elliott and colleagues' (1999) guidelines provide a fairly detailed description of elements pertinent to good quality qualitative research. These are listed as:

- 1). Owning one's own perspective
- 2). Situating the sample
- 3). Grounding in examples
- 4). Providing credibility checks
- 5). Coherence
- 6). Accomplishing general versus specific research tasks
- 7). Resonating with readers

Elliott *et al.* stress however, that these guidelines are not comprehensive and should not be used in a rigid or restrictive way. Indeed, Barbour (2001, p. 1115) asserts that '*overzealous and uncritical*' use of checklists '*can be counterproductive*'. With these cautions in mind, I have attempted to address the areas covered by these guidelines throughout my research. Some of these issues are covered within the methods section, which is intended to provide a transparent account of the research procedure; other of the issues are covered more explicitly in subsequent sections, such as the reflective account (section 6). The commitment to addressing some of these issues is summarized below using Elliott *et al.*'s (1999) criteria as a framework.

I have attempted throughout this research to 'own my own perspective' both in indicating the origin of my interests in this research topic and through personal reflection on my own thoughts, assumptions and experiences within my reflexive diary. As well as reading widely about the philosophical underpinnings of phenomenology and the IPA approach, I attended an IPA training day, which allowed for practicing interview technique. As IPA depends on generating 'rich' data from interviews, I also read extensively on the topic of conducting quality interviews. The final interview guide was agreed in collaboration with my research supervisor and a further supervisor specializing in qualitative research. Interview skills were practiced and honed within the pilot interview and the initial two interviews, which were not included in the analysis for reasons already mentioned. Within the interviews I was mindful of the importance of posing open questions, of '*listening with an evenly hovering attention*' (Kvale, 1996) and of trying to assist participants to provide open narratives. I also transcribed the data myself, allowing

me to become very familiar with the texts and fully ‘immerse’ myself in the data even before the point of analysis.

I have sought to provide relevant contextual data about my research participants (see sections 4.2 and 4.3.1) as well as reflecting on my relationship to them and how this may have influenced my research findings. These considerations are highlighted within my reflective account of the research process, in section six.

The iterative nature of the IPA process requires a constant checking of new themes against themes generated from earlier accounts, thus ensuring that the themes remain true to the data. Credibility of the themes was further sought by using a second coder for a sample of the interview transcripts (2:8). This revealed a very close consensus between my own codes and the independent rater’s codes.

Transparency of the analysis is achieved by including substantial verbatim quotes to illustrate themes. This allows the reader to judge the validity of the interpretations and to consider possible alternative interpretations. Moreover, an initial description of the narrative produced by each participant is given in section 5.1 in order to provide a coherent illustration of the movement of the analysis from an individual to a group level. Figure 1, shown in section 5.2, is intended to provide the reader with a clear illustration of the proposed superordinate and subordinate group themes. A further illustration of each participant’s contribution to the group themes can be seen in the table in appendix 8, while an example of a coded interview is included in appendix 7.

#### **4.7. *Ethical issues***

In the planning stages of the study, ethical issues were considered. In asking clinicians to talk about their experiences of clinical work, there was the potential for confidential clinical information to be conveyed within the interview. Firstly, this was dealt with by reminding participants at the beginning of interviews to try to omit

any potentially identifying client information (such as names) from their accounts. Secondly, if participants did inadvertently mention any identifying information, it was ensured that only the researcher, who was bound by professional ethics of confidentiality, listened to the interview recordings. The researcher then ensured that any confidential information was omitted from the subsequent transcripts.

Prior to beginning the study, a favourable ethical opinion was given by the local research ethics committee (see appendix six). Following on from this, the local NHS board granted research and development management approval.

#### ***4.7.1. Reflective note on ethical considerations***

I was aware of the ethical considerations inherent within a research process that asks clinicians to talk candidly about their personal reactions to their work. I was particularly aware of my own position as colleague (and particularly my 'junior' role as trainee) to my potential participants and of the potential for the interview process to evoke strong emotions and intimate reflections. I sought to address these issues within the research design and process by making the research aims as explicit as possible (without 'priming' participants) through the process of seeking 'processual consent' rather than 'one-off' consent and by conducting the interviews in a respectful and open manner, which allowed for participants to be in control of how much or how little they discussed facets of their experience. Finally, I was careful to monitor participants' emotional reactions within the interviews and had arranged to discuss any concerns I might have with participants, should the need arise.



## 5. Findings

In the following section, participants are referred to by an anonymous, randomly allocated participant identification number (PIN).

### 5.1. *Analysis by individual*

All eight participants were able to talk in depth about diverse clinical experiences, which they felt stood out for them in some way. In order to provide the reader with some understanding of the context of the individual experiences, and the range of clinical work discussed, an account of each participant's narrative, summarized under idiosyncratic core theme headings, is given in the following section. This is followed by a move towards group level analysis in section 5.2, where commonalities and differences within these shared experiences are drawn out. The way in which individuals' accounts fit into group level themes is shown in Table 1 (Appendix 8).

#### **P03: Individual Narrative**

P03 discussed two clinical cases. One was a historical case involving a young girl who had been sexually abused, the first such case this clinician had encountered in her early CAMHS career. The second case was more recent and involved the death of a young person following transfer to another service.

#### **Client getting inside the therapist**

The therapist describes similarities in the way these young clients act upon her. The feeling is of the child 'getting inside' the therapist in the language used to describe these experiences. This 'getting inside' is also what allows the therapist to empathise with the client. At times the therapist conveys an impression of taking on aspects of the client's experience.

### **Maternal feelings**

The therapist describes that these most needy and uncared for young people seem to draw out some sort of maternal instinct or drive in her. There is a deep empathy with the child's situation and the lack of love the child receives.

### **Impact on therapist's self**

The two clients are also seen to pull strong feelings out of the therapist. The client makes the therapist feel things at a level that she didn't at first know she could feel, bringing some aspects of herself which she felt to be 'primitive' or hidden into awareness. For her this was an unsettling and frightening experience. She felt 'deskilled' and less in control of her feelings, touching on feelings of 'madness'.

### **Exposure**

In describing the impact of the abuse case, the therapist becomes aware of some of the brutal and harsh realities 'out there'. She describes that the 'superficial' picture of abuse that she previously held in her mind becomes infused with a detail and colour that brings it to life. This new knowledge can no longer be ignored.

### **Acting in the present**

These clients are seen to continue to act on the therapist in the present, here manifesting as a re-experiencing of the emotion associated with these cases. This is experienced by the therapist and the researcher, within the interview, in a number of ways.

### **Responsibility-Managing the impossible**

This therapist expresses a sense of responsibility for these clients that seems to go beyond the realms of professional responsibility and also reasonable personal responsibility. There is not just responsibility for the clinical care of the client but a

sense of being the 'lifeline' for the client. The guilt of losing a child remains a permanent burden for this therapist.

### **Taking work home**

#### **The double-edged sword**

The work is described as impacting on the therapist's sense of herself as a parent. She has picked up knowledge about parenting, which has served as a useful guide in her own parenting, managing to avoid some parenting pitfalls. There is also however a feeling that the work can intrude on home life in a less helpful way. She is aware of how she has been overprotective towards her child and continues to be an 'anxious' parent.

This therapist also expresses a very literal desire to take 'work' (the child) home at one point, even though this is recognised as going beyond the typical boundaries of the professional role. The child's neediness is described as leading to a shift in the therapist's customary boundaries.

#### **Closeness to home**

The therapist conveys a need to separate work from home – to erect boundaries and to have a space where work can't get to her. In one case the fact that the child lives nearby seems to make it more difficult to enforce this psychological separation. Instead the 'reality' of the child's situation intrudes upon the therapist's home space.

#### **Intrusive thoughts**

Thoughts are also carried home in a variety of ways. These again are conveyed as being intrusive but also seem to act as a way of safeguarding or protecting the client.

#### **Processing complex emotions**

There is a theme of developmental progression in this therapist's work through recognition of the importance of 'processing'. Supervision is recognised to be important for processing but experience also seems to play a big part for her. The

increasing sophistication of her 'processing' allows her to make sense of some of the feelings that arise in sessions.

'Processing' seems to be a sensuous activity, – involving seeing, feeling and hearing a session. This is seen as being important both for her and the way that she helps families understand the problem. There is less of a need to avoid and to protect herself emotionally as she gets better at processing her emotions; hence she now dares to ask the questions that need asking. Her confidence in her ability to formulate and make sense has grown over time.

### **Live Processing**

Processing also seems to occur 'live' during the interview. Things begin to shift and make sense as the researcher and therapist jointly pick apart her story – this 'processing' is also reflected in emotional reliving as parts of the story are told.

### **Limitations to supervision**

Although supervision is recognised as important, there is a limitation to this. The raw, painful parts can't be 'supervised' away.

### **Confidence to survive**

This therapist describes a progression in her confidence to cope with other people's strong emotions and also her own strong emotions, which are awakened by the work. She seems to have gained a sense of mastery, or acceptance of the presence of difficult feelings, which she feels might previously have been feared and avoided.

#### **P04: Individual Narrative**

P04 discussed a recent case involving working with a young person with anorexia, who was admitted to inpatient care.

#### **Responsibility**

The therapist discusses how she adapts to a new role in terms of a growing sense of responsibility as a more senior member of staff. She talks about her anxiety and fear about having the ultimate responsibility for this case, which she characterises as realising that she now is the 'shoulders' upon which responsibility falls and that there is no-one else to 'pass the buck' onto. The weight of the responsibility seems to be underpinned by the seriousness of the client's condition, with the therapist having to make life/death decisions about the client's care. She conveys a feeling of isolation within this decision-making. This is further drawn out by her indication that there are layers of responsibility (i.e. she is responsible for advising staff and parents, who are in turn responsible for the child), something that paradoxically appears to undermine her sense of control over the situation, while simultaneously demanding greater authority from her.

The therapist seems to be led into a position of over-responsibility for this client, something that in part appears to relate to her sense of having formed a warm and positive relationship with this family. The therapist puts pressure on herself to 'get it right', almost as if there is an expectation of infallibility.

#### **Taking work home**

The therapist's self-perceived failure to be faultless seems to lead to feelings of guilt and an over-extension of the ordinary therapeutic role, leaving her phone on during her holiday. The client(s) are taken home with her in her thoughts (she dwells on them) and also enter her dreams.



### **Balancing responsibility**

Finally, as a result of working through this case, the therapist indicates she is entering a stage of learning to balance the responsibility. She comes to some acceptance of her therapeutic limitations and is able to give some responsibility back to the client. She is learning to be able to fail successfully (i.e. accept failure without undue guilt). She also has begun to recognise the need to gain support from colleagues and to share some of the responsibility.

### **Personal/Professional Boundaries**

This case seems to have challenged the therapist's conception of personal/professional boundaries and led to questioning of the permeability/fixedness of these boundaries within therapeutic work. This seems to be an uncomfortable challenge, which is still being actively thought through.

The parents of this child seem to push the boundaries, which the therapist responded to by shifting away from her 'therapist role', allowing more of herself and her own experience into the therapy room.

This move seems to have created a tension between an idea of 'therapist' me and 'ordinary/non-therapist' me and a questioning of how these roles are played out in the therapy room. There is some sense of incongruence in the therapy role, in having, with this particular case, to play the 'dictator'.

This client's particular difficulties also seem to tap into aspects of what may be perceived as non-therapeutic emotions, again seeming to create tension within the therapeutic identity. There is an acknowledged feeling of 'envy' towards the client and a conscious struggle to accept certain facets of the client's behaviour. The client's problem has a personal resonance for the therapist.

### **Self-doubts**

The therapist expresses self-doubt and questions whether she has made the right decisions with this client. The 'if only's' are a sort of critical presence within the therapist's experience of this case and highlight a tension between the therapist's self-perceived 'rational' self (I did all I could) and emotional self (needing to do more).

### **Personal gain**

There is a realisation for this therapist that her clients provide her with a 'feel good factor', which is carried home as a 'high' at the end of a busy day. There seems to be an appreciation of the closeness/intimacy of being 'let in' to a client's inner life.

### **Self-Change**

The therapist talks about learning to limit her exposure and counterbalance the 'horrors' of therapeutic work. She takes things 'frivolously' out of work. She feels that she has become less judgemental of others as a result of her work but also is less tolerant of intolerance, something she sees as a 'double-edged sword'. She feels she has gained confidence in 'tricky situations' as she has developed at work, together with an acceptance of failure, a move towards being 'good enough'.

### **P05: Individual narrative**

P05 discussed a fairly recent case concerning a child with an eating disorder. The focus of the work however was with the parent of the child. The narrative focuses on the way in which the case parallels aspects of the therapist's own past experience.

#### **Touching on personal vulnerability**

This particular case seems to touch on an area of personal vulnerability for this therapist. The case has similarities to her own past parenting struggles and this seems to leave her feeling anxious about her ability to take on the case and full of self-doubt about her professional competence. She experiences some feelings of envy towards the client, which seem dissonant with her sense of professional self. There is also an indication of a blurring of the distinction between therapist and client, with the therapist becoming unsure what feelings belong to her and which belong to the client. The way that this touches on personal issues for this therapist seems to make it harder to distinguish between 'me' and 'client' as she describes really 'tuning in' to what the client is feeling.

#### **Going through an emotional process**

The parallels between the therapist's own experience and this particular client's experience seem to lead to a revisiting of the past for the therapist, where painful emotions are 'thrown up'. She spends time thinking about and reflecting on her own perceived mistakes in parenting and experiences regret, guilt, sadness and a desire to 'wind the clock back'. However, she perceives there to be benefit in 'going through the process' – it has been a 'useful' experience, which she feels has allowed her to progress professionally. This appears to have been an effortful process, requiring her to take things home at night to be 'thought about', both alone and in conversation with her family.

## **Responsibility**

The clinician talks about her fear of letting the client down (by her perceived incompetence) and needs to 'push herself' to take on cases she knows she will find difficult. This seems to be driven by a sense of responsibility to the team.

There has however been a shift in her attitudes towards responsibility, with a consideration that maybe she doesn't need to 'give her best' to every case. There is a sense of her feeling uncomfortable and uncertain about the meaning of this shift.

## **Taking work home**

This case prompts work to be taken home in a number of ways, which is experienced as unusual for this therapist. The painful feelings she experiences in working with this case cannot 'afford' to be experienced at work, as if it is feared that the costs of this might be too great. She has, therefore, resorted to 'taking work home' as a coping strategy, using her family to help provide emotional comfort.

More recently, work has been taken home in physical exhaustion and tiredness, which reduces her ability/ desire to socialise. Additionally, the work more generally is perceived to have impacted on her parenting, creating fears for her own children's safety and stopping her from allowing her children freedom. She describes the importance of being helped to work through these fears by her partner, arriving at a more 'reasonable' position towards her children's safety.

## **Importance of support**

For this case, support has been vital to helping the clinician cope with the work. Support, encouragement and affirmation from colleagues has helped her to gain confidence professionally. Being able to be honest about her insecurities and having a colleague who was 'tuned in' to how she was feeling was perceived as essential to this. Despite this however, there is a sense of her lacking emotional support with this case and having to carry an emotional burden alone. She reflects that she might have

used therapeutic support, had it been accessible to her. Supervision is also seen as important to supporting her but this has 'slipped by the wayside' due to case load pressures.

### **Signs of pressure**

The therapist talks about a number of negative feelings about work at present. She feels 'worn down' by the 'grind' of cases, feeling as if she is 'fighting a losing battle' with complex cases where she cannot effect any changes. She feels a need for a break and has begun to withdraw from social contact outside of work because of her fatigue. She feels that cynicism is 'creeping in' and finds this a 'depressing' shift from her usual position as the 'eternal optimist'.

### **Professional Development**

The therapist talks about a growth in confidence in managing her own feelings, to know that she can experience painful feelings and survive them. This leads to the feeling she can 'take on any case'. She feels more competent and confident professionally as compared to when she started and has become comfortable with 'using herself' in therapy. There is also a perceived shift in her ability to separate her own feelings from those of her client, which she relates to a greater theoretical understanding of dynamic processes in therapy. She also has developed a more compassionate stance towards herself and her perceived shortcomings, giving herself 'a break' from self-criticism.



### **P06: Individual Narrative**

P06 discussed a historical experience of working with a young person with an Autism Spectrum Disorder. The focus of the narrative however was on difficulties within the clinical team and the therapist's experience of personal illness, which coincided with working with this case.

#### **Being a lone soldier**

This therapist's account of her experience is replete with metaphors of battle and struggle. She uses rich descriptions of feeling alone at sea to convey her feeling of being 'dumped' with a difficult case. Support felt unavailable to her, both because of her internal/self expectations (not wanting to look like a failure/admit weakness) and because she perceived there to be an organisational expectation that she should 'get on with it' without complaining. There is a strong sense of her cries for help not being heard. She feels that she was required to 'soak up' the emotions of the work and that this task eventually led to her becoming unwell.

#### **Responsibility**

Part of what this therapist seems to have found difficult within her role relates to the weight of responsibility for nurture (people being dependent on her). Her illness experience seems to have contributed to a fundamental shift in her parameters of personal responsibility for her clients. She describes having reached a level of realistic responsibility within her work, delineating her own boundaries more clearly. She has come to accept the limits to her own role and is able to 'let go' of families, rather than feeling she has to 'hold on' to them.

Within the team she has learned to share responsibility with others and has reached a balance between dependence and independence. With her clients she describes learning to work in a more 'collaborative' way and shuns the over-responsibility of the expert role, which she formerly endorsed. This seems to allow her to hand back some responsibility to families and not to set herself up as 'having the answers' or necessarily being able to help.

## **Organisational Support**

The therapist talks about the impact of splits/fragmentation within the team and how this impacts on her well-being. This seems to lead to a professional isolation and lack of support. The additional loss of a leadership/paternal figure within the team seems to lead to 'unexpressed anxiety' within the team. There is a sense of the team becoming a 'dysfunctional' family, with no parental figure to contain the team distress.

Organisational culture is a strong theme, with the therapist experiencing an expectation of martyrdom. She conveys an experience of organisational 'madness' or 'pathology', which seems to have infected the team, leading to a 'survivor' culture. A shift in the organisational culture seems to have allowed her to reinvest in her job and to manage her workload in a way she perceives to be healthier.

## **Attack on professional identity**

The experience of this particular case is described as leading to unpleasant feelings, which seem to challenge this therapist's sense of professional identity. Her experience is of feeling 'clueless' about a case and not-knowing how to fulfil her professional role. She describes a pressure to 'know' the answers yet she is unable to help and feels deskilled and overwhelmed.

## **Illness Experience**

The therapist describes an experience, which she labels 'burn-out', or becoming both physically and mentally unfit to work. Her reflection on this, now historical, experience conveys a sense of the illness experience as being frightening and threatening loss of the healthy self.

The acute stage of illness progresses into a 'recovery' phase, where she is able to accept a 'patient' role, both allowing others to help her (going to therapy) and also putting her therapeutic skills to work on herself.

The therapist describes a number of perceived benefits of the illness experience, both on a personal and professional level. She feels that the 'insight' into illness has facilitated empathy with her clients. There is also a feeling of getting life into perspective, of learning to value her health and her independence and seizing the day. She has become more aware of, and comfortable with, her own weakness and vulnerability and is aware that she needs to look after herself.

### **Changing Boundaries**

There is a repeating theme of this therapist learning to draw tighter boundaries for herself following her illness experience. She has learned to be forceful and unwavering in demanding support from colleagues and is unwilling to tackle certain cases alone. She has learned to say no to colleagues without feeling guilty. She is also clear about the need for a work/home boundary as far as possible and the need for a 'sanctuary' from work. Her need for tighter boundaries/parameters within work is facilitated by a wider shift in the team culture/organisation. These shifts seem to be containing or reassuring for this therapist; she has people 'nearby' on a seemingly literal and metaphorical level.

### **P07:Individual narrative**

P07 discussed a recent experience of working with the parent of a referred child. The focus of the work was on the parent's history of childhood sexual abuse.

#### **Impact of the therapeutic process**

The therapist talks about the visual impact of hearing about sexual abuse in detail. This is strikingly powerful for her to the extent that she feels she is actually witnessing a child being abused. The visual imagery seems invasive and she has to make active efforts to shut it out. She describes a physical toll/ bodily impact of this work, with her feeling 'drained' and 'shattered'. She also feels hunger afterwards, as if the work is literally starving or draining her of energy. There is a strong theme of the therapist having to soak up or absorb the emotions of the client. At times she seems almost to take on aspects of the client's experience. The therapist experiences parallel emotions, feeling how the client feels, experiencing what the client experiences. At times this seems to lead to confusion over whether what the therapist experiences is 'her or me', as if there is a danger of merging with the client and being unable to separate.

#### **Responsibility**

The therapist talks about the pressure of responsibility towards the client in 'not wanting to let her down'. She feels that a 'link' has been made with the client and feels responsible for upholding this and maintaining this link. She talks of a pressure/ responsibility to 'fix/cure'. There is a doubt about whether she can do this and whether she can 'do enough' or be a good enough therapist to accomplish this or indeed whether she might 'harm' the client. The therapist describes a difficulty with this case in having to live with therapeutic uncertainty.

The therapist reflects on her former inability to say 'No' and to put limits on her levels of responsibility at work, something that she feels ultimately led to her becoming unwell. She feels that she has learned through her illness experience to have a more realistic level of responsibility and about her own limitations.

### **Owning undesirable aspects of self**

The therapist recognises and talks about experiences of the self that are more difficult to own. She recognises that her empathy can go 'beyond acceptable norms'. She says that she 'enjoys' this work, which she feels to be a sort of 'perversity' on her part. She has also come to recognise however that in the past her work has served as a distraction from her own unhappiness and her recognition of this seems to have allowed her to become healthier.

### **Exposure: Being drawn into an unhealthy world**

The therapist talks about the experience of inhabiting the 'crazy' therapeutic world, which has a different dimension to the 'everyday' world. Here she is exposed to things (horrors) she wouldn't otherwise encounter and experiences alteration to her 'baseline of acceptability'. She learns to 'accept' what she previously thought of as unacceptable. She describes an experience of almost becoming consumed by this 'crazy' world of trauma, unable to look away. She describes being drawn, for example, to reading books about abuse on holiday, almost as if she has a responsibility to remain 'alert' to these experiences. She indicates however that there has been a shift away from this behaviour to recognition of the need to do 'normal' and 'ordinary' things.

### **Professional/personal boundaries**

The therapist talks about the experience of taking this case home, something she tries to counteract through effortful distraction. This seems hard to do and requires persistent effort. For this therapist there is also mention of taking 'home' or personal aspects into work; of her home life influencing her reactions to her work. She talks of being unable to leave all aspects of her personal life at the door and is aware of her own 'self' entering the therapeutic space.

### **Processing**

This therapist describes 'processing' as a key aspect of the therapeutic task with this client and a key learning experience for her. There is a need for 'mind space' to do



this, and also at times a need for support from others to ‘process’. The processing is construed as a sense-making/ detective process, where emotions are allowed to be felt but don’t cause distress. It is a way of disentangling/ filtering out her self from the client through self-reflection. The processing is seen as a way to expel/get rid of emotions (wringing oneself out) and is seen as necessary and beneficial for the therapist, seeming to provide her with a greater sense of control.

### **Protecting oneself**

The therapist has come to recognise and learn ways to protect herself at work. She puts limits on the number of intense cases she feels able to take on and structures her appointments so as to protect herself as much as possible. She feels able to meet her needs for sharing/ debriefing, even if this means phoning a colleague after work and has learned that her employer also has a responsibility toward her. She protects herself by limiting her exposure to horror outside of work (not watching/reading horrific things) but also in the present interview, by changing topic/ not allowing thinking about the horrors she has witnessed.

### **Supervision/support**

The therapist indicates a particular need for support through uncertainty with difficult cases. Support from supervision/ colleagues allows her to explore and make sense of her feelings. There is a change in her confidence within supervision, a move from defensive practice to unapologetic uncertainty.

**P08: Individual narrative**

Participant 008 discussed a recent experience of working with a parent who had a history of abuse.

**Fear of harming**

For this therapist, much of the narrative revolves around her anxiety about working with this particular client. She expresses a feeling of being burdened by the client's expectations of her, a position of daunting responsibility. She is aware of how important she appears to have become for the client, whom she feels perceives her as the 'axis'. It is this facet of the relationship that appears to lead to the therapist feeling as though she is 'holding' the client and fearing that she may inadvertently harm or let down this person who has placed trust in her.

**Making a link**

The therapist discusses a feeling of 'emotional involvement' with this client, which appears to lead to a feeling of tension and discomfort for her. She reflects on the way in which the client's experience links in with her own life experiences and how this, she feels, allows her to empathise with the client.

**Reaching the client**

The therapist discusses how she has built a rapport with this client and how she can be left feeling overwhelmed by the client's apparent investment in her. She relates this to feeling that she has been able to 'reach' the client, making a connection which results in the client sharing intimate details and experiences.

**Support and supervision**

The therapist discusses the importance of supervision and co-working with colleagues in managing her reactions to this case. This is characterised as being able

to share the burden of anxiety and uncertainty so as not to be left feeling 'overwhelmed' or isolated.

### **Self-development**

This therapist describes ways in which her therapeutic work has influenced her parenting and family life, seeming to give her greater sensitivity to her children's emotional life and a feeling of greater emotional control within her life. She appears to have reached a position of greater self-acceptance and can accept her failures both on a personal and professional level. She recognises a greater professional confidence, which appears to allow her a greater creativity in her therapeutic work, an ability to draw upon multiple resources in imaginative ways.

### **P09: Individual narrative**

P09 described a historical experience of working with a young person with anorexia, something that had prompted her to make some professional life changes.

#### **Transformation**

The therapist described her struggle to effect therapeutic change with a young anorexic client. The struggle is described not in terms of emotional impact but rather through the way in which her perceived therapeutic 'ineffectiveness' pricked her intellectual curiosity and drove a desire to learn and improve her practice. The clinical event is pertinent for her in the way in which it instigated a series of challenging life changes, which are again described in terms of learning and development.

#### **Therapist's needs**

The therapist describes how this case indirectly led to awareness of the way in which her work meets her own needs. This is characterised by her self-perceived need to be 'helpful', which she feels has psychological importance to her. She recognises the way in which this need is addressed through her work and how an inability to meet this need can leave her vulnerable.

#### **Enthusiasm for job**

This therapist described her love of the work and a feeling of privilege in being able to work as a therapist. She indicates enjoyment of her role, particularly in working creatively with her clients. She described a fascination and 'respect' for unconscious processes within her work.

#### **Challenges to helper identity**

Difficulties within therapeutic work for this therapist are described by the way in which certain cases have challenged her 'helper' identity and led to self-scrutiny and

self-doubt. The emotional impact of working with a 'desolate' child, whom she feels unable to help is explicated.

### **Importance of colleagues**

The therapist describes the importance of her colleagues in helping her to regulate the effects of difficult cases, through providing reassurance and affirmation of her competence at times when this feels under threat.

### **Avoidance**

The therapist seems to protect herself from the impact of her work through avoiding certain activities, such as reading 'heavy' literature. This seems to help her to create a balance, which is further achieved through managing her caseload.

### **Spirituality**

The therapist describes a number of spiritual aspects to her work, achieved through working creatively with clients. She indicates a greater 'playfulness' in her therapeutic work, which she perceives to contribute to her therapeutic success.



### **P10: Individual narrative**

P10 describes an ongoing experience of working with a young person who is self-harming. This leads her to draw on some comparative experiences of working with self-harming adolescents.

#### **Clinical responsibility**

The therapist talks about having to use clinical judgement in a situation where the young person's life could be at risk. She discusses being unable to influence the volatility of the home situation and of being unable to get a clear picture of the difficulties. The life/death nature of the clinical decision-making seems to lead to anxiety, which she is aware could colour her judgement. She worries about her competence, whether she is 'doing enough' has 'missed something' or has 'misjudged'. She is aware of her fallibility, yet the situation seems to demand an infallible, omniscient clinician to ensure safety.

#### **Vulnerability: Life/death situation**

The vulnerability of the young person seems to feed into her anxiety about the young person. She is 'frightened' for their safety, aware that a life is 'at risk' and that the young person is in a 'bad way'.

#### **Putting limits on responsibility**

The therapist seeks to deal with this impossible task by 'sharing her anxiety' with others, seeking back up and affirmation from colleagues. She has an awareness that the seriousness of the situation can tip her into a 'rescuer' role and that she needs to keep her boundaries and keep this in perspective. She has learned that clients are not her 'private possession' that she is not 'number 1' and that she does not and should not have to hold the responsibility by herself.

### **Taking work home**

Work is taken home as worry. She is 'left concerned'. She has thoughts going round her head, thoughts that 'catch up with her' unexpectedly when she rests in bed. There is a need for a place to think, feel and say but she is unable to find this in the hectic work schedule and so is forced to find this place at home.

### **Connection with client**

The therapist talks of the need to make 'a connection' with the vulnerable client, getting the client to agree to come back, again a way of holding on to the client. At times she finds herself 'going to a deeper level' with clients. This is a 'calm' experience of 'joining, being alongside a client, which she finds a satisfying experience.

### **Impact on the total person**

The therapist emphasises that the work impacts on her 'whole being', both body and mind. The client gets into her 'system'. It seems to have a life force of its own, demanding to be thought about and catching her unexpectedly. It is as if she has been infiltrated in some way by the client's pain. She is unable to talk to others 'outside' the profession about her work, conveying an impression of almost being contaminated or infected by her work.

### **Resources being drawn out**

Again the therapist talks about 'giving out emotion' and being 'drained, worn out, washed out' by the work. It is as if she is being used up by clients or becoming depleted.

### **Support: Relationships with others**

There is a need to be understood, which is difficult to access from friends and family. She feels the need for 'relatedness' or a connection with others after a difficult case. There is however a 'respect' for clients, which prevents her from sharing her work with others outside work.

### **Self-care**

There is a need to self-nurture, to protect herself from the effects of the work. She expressed a need for a balance in her life and to receive as well as give of herself. The need for balance can also become a strain, demanding use of her already depleted energy. Humour is also seen as important to her - helping to keep her grounded.

### **Signs of Strain**

The therapist talks about changes in emotional reactivity recently; becoming 'crabbit' and showing 'out of proportion reactions'. She feels fed up with organisational demands and wonders if she can sustain this work at its current pace.

### **Self- Changes**

The therapist indicates a need to gain a balance between emotional over-reactivity and under-reactivity in her work with clients. This is characterised as coming to a reasonable level of emotional reactivity, where she is concerned for clients but not 'jumping at shadows'.

On a personal level she feels she has gained tolerance towards others, but ponders whether 'tolerance' might be a defence serving to protect her from conflict. She also expresses a new freedom in no longer feeling she has to please others, something which again is seen to be a double-edged sword.

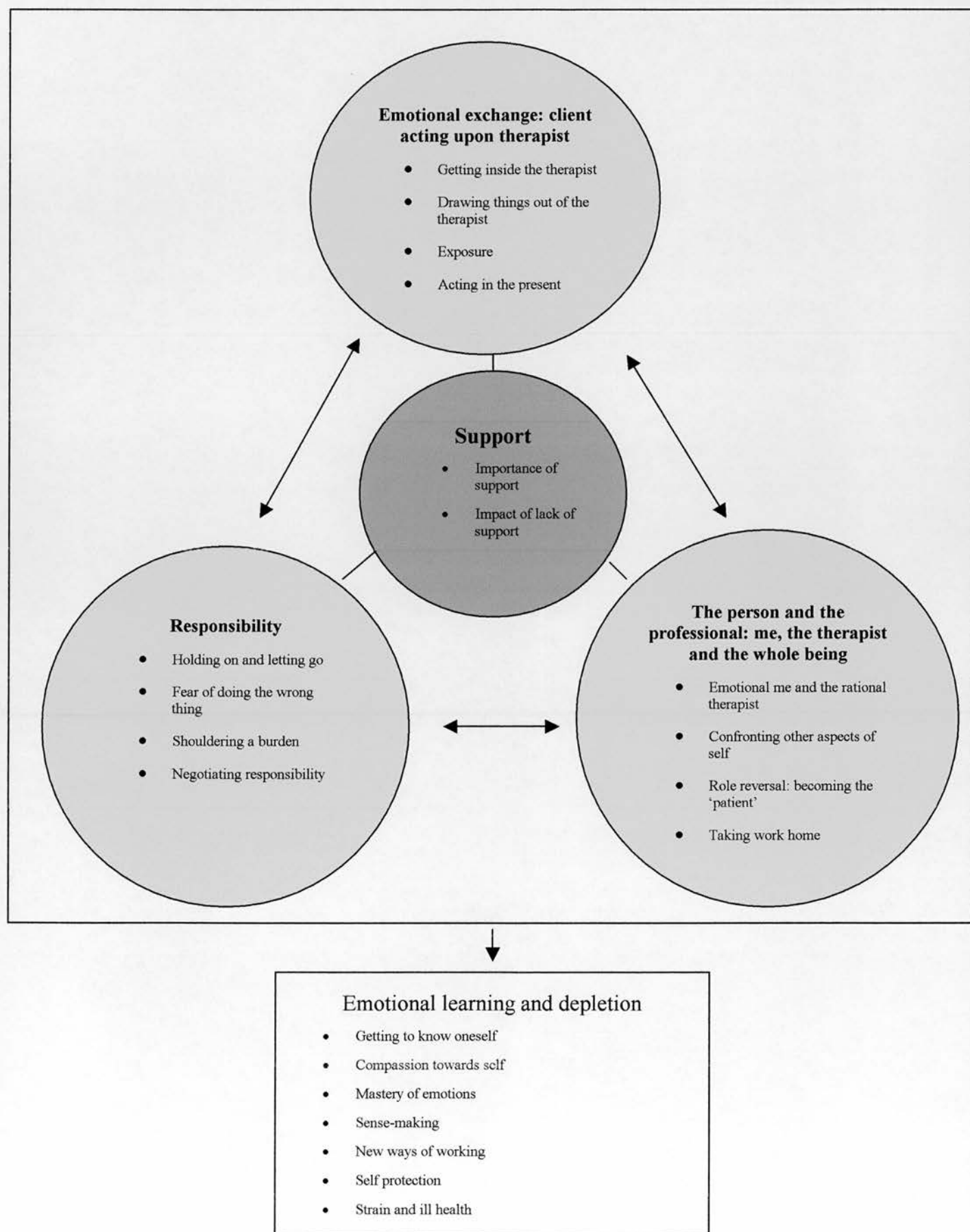
## **5.2. Group level themes**

In the following section, group level themes are discussed. Five superordinate themes, which seemed to best represent the essential shared qualities of the participants' experiences, are illustrated in Figure 1. The themes were:

- Emotional exchange: client acting upon therapist
- The person and the professional: me, the therapist and the whole being
- Responsibility
- Support
- Emotional learning and depletion.

Each superordinate theme has a number of sub themes, which aim to capture the individual qualities and differences within these shared experiences. Themes are illustrated with the use of verbatim extracts from interviews. Participant numbers and line numbers are shown at the beginning of each extract. Superfluous text, which did not illustrate the extract's essential meaning, has been suppressed where indicated. An explanation of transcript notations can be seen in appendix five.

**Figure 1: Superordinate and subordinate group themes**



Clinicians' experiences of therapeutic work



### **5.3. Theme one**

#### **Emotional exchange: client acting upon therapist**

This superordinate theme refers to the emotional exchange within the therapeutic encounter and is conveyed in multiple ways across participants' accounts. There is a strong sense of there being a powerful emotional impact of working with these particular clients. Several participants' accounts convey a sense of clients metaphorically 'putting things into' them and 'drawing things out' of them. There is thus a sense across all narratives of the client acting upon the therapist in powerful ways.

##### **5.3.1. Putting things into the therapist**

This theme is represented in all accounts in a number of ways. The 'putting into' the therapist is conveyed variously as an invasive, protective, passive or symbiotic process, as will be illustrated in this section. P03's narrative provides a particularly rich illustration of one facet of this theme. For this therapist, the feeling is of the client emotionally getting inside the therapist, in a seemingly insidious way. There are metaphors of unwanted 'penetration' and 'getting under the skin' in the language used to describe these experiences. These descriptions lead to an image of the therapist's thoughts and body being assailed, or invaded in some way:

*P03: 85-87*

*she was there almost kind of penetrating my thoughts at times and it wasn't a conscious thing, she would just constantly pop into my mind*

*P03: 328-330*

*..it's the most neglected, rejected, uncared for youngsters I think that get under your skin and stay under your skin...*

Participant 07 also conveys an impression of involuntarily having ‘bad stuff’ put into her head and feeling a need to purge herself of this in some way:

*P07: 281-283*

*...but it was more to do with getting rid of some of the bad stuff, some of the stuff that I didn't want to have in my head and the images I didn't want to have in my head.*

There seems to be an effortful quality to the ‘getting rid of’, as if the participant has to block out the ‘bad stuff’. Perhaps this is her way of coping with the experience:

*P07: 290-292*

*I'd throw myself into something particularly complex on the computer or do something that really took up my mind.*

Again, another participant talks about the client being inside her ‘system’ after work and an apparent need to rid herself of this invasion:

*P10: 322-324*

*I've seen me maybe phone a friend or family and just talking about anything, just to get it out of your system a bit.*

This can be contrasted to P04, who talks about a more benign experience, as though she has some control over the process rather than being infiltrated, perhaps indicating a different facet of this relational process:

*P04: 121-126*

*when you see people at such a regular interval you do become, it is the curiosity of what's happening I think as well as just the interest there. You become..it sounds really boundary less if you say you become part of their lives but they become part of your, your mental life.*

Interestingly, P03 also initially conveys an impression of this being a more voluntary process. Her use of the word ‘kept’ seems to express a feeling of needing to look after, guard or ‘keep safe’ the child. This would again suggest that there might be two sides to this experience, one that is influenced by the therapist and one that is

influenced by the client. At times therefore, the experience is of the client 'getting' inside, while in other instances, the experience is of the client being 'taken' inside in a seemingly protective fashion:

*P03: 73*

*I think I kept the wee girl constantly in my mind, sort of in work and out of work*

In a similar way, P10 talks about 'needing' to give the client time to be thought about, almost as if this is a duty she has to perform. Her description conveys a sense of the client remaining with her, almost like a presence that has its own voice and life force inside the therapist:

*P10: 351-354*

*and you maybe go home and have umpteen things to do in your private life and it's actually when you lie down it just kind of says 'I need thought about'.*

*P10: 374-379*

*I think at times it just **has** to be thought about. You just need at some point need to stop running from things as you do with your activities and just go through it and try and have a bit of patience for yourself and allow yourself just to think about it and it just wont be rushed away.*

Other participants referred to the demands of having to 'soak up' the client's emotions, a process of emotional absorption that has a more passive feel, but which nevertheless continues to evoke an idea of the therapists' body and mind being used by the client:

*P06: 139-140*

*So I think a lot of what I was soaking up was the parents' anxiety about this boy*

Two participants indicate that there is a need to limit the 'soaking up', or to be able to somehow rid oneself of the emotions after a session:

*P06: 699-703*

*I can't soak up. I think there's a certain amount of erm, soaking up to be done in this kind of work but I'm not going to do it till I'm saturated and can't soak up any more but I think I'm much more aware of my limits now.*

P07:132-135

*you're like a sponge almost and you soak someone's emotions up and if you don't have a kind of, I don't know, some kind of container to pour them back into, you're left holding them.*

Other participants described not only a 'soaking up', but the feeling of taking on aspects of the client's experience, with parallels between how the client feels and how the therapist feels. This has an almost symbiotic quality to it. For some participants, the influence of the client seemed to lead to the distinction or boundary between therapist and client becoming blurred, as if a sort of merging is taking place, with the therapist experiencing for the client. This calls to mind psychoanalytic concepts of transference and projective identification and will be discussed in section eight.

For participant 007 this was particularly powerfully described, to the extent that the therapist both *feels* and *experiences* the client's abuse:

P07: 162-169

*I: So it was all very vivid for you hearing about it?*

*007: Because it was vivid for her, yes. Very. And I suppose it did feel abusive, you know, it did feel. Because I was probably in some way kind of like vicariously abused in some strange way because you know, that's, you know, you kind of think 'God', you know 'burr' [makes shivery/disgusted noise] erm and you have those experiences.*

For two participants, the experience of emotional exchange seems to lead to an uncertainty and confusion about whom the feelings belong to, something that can perhaps only be seen in hindsight:

P07: 255-258

*I had to be, in that piece of work, I had to be really open to having to work out what was me and what was her. What was her stuff and what was my stuff. What am I feeling? Is this me or is this her?*

P05: 598-600

*Probably in retrospect, a lot of the pain that I was feeling was her pain. But it really felt like my pain that I took home with me.*

### 5.3.2. Drawing things out of the therapist

This sub theme is characterised by a sense of the clients drawing emotions out of the therapists. This is represented across the majority of accounts. For many there is an impression of therapists providing some sort of emotional sustenance or emotionally 'feeding' clients and a feeling of depletion accompanying this.

P03 illustrates how her maternal feelings are drawn out by a child. The child is seemingly like a voraciously hungry baby, a 'bottomless pit':

*P03: 94-100*

*There was something about what that little girl brought out in me was 'I want to be looked after and cared for' and I think other people who came across her would say similarly. You know other workers would go home, would talk about going home at night and she would stay with them, she was quite searching, she really pulled a lot out of individuals [coughs].*

*P03: 147-155 [148-152 suppressed]*

*the young person had such an overwhelming need and almost that need couldn't be and wasn't being met... There was just a, it felt as though she was a bottomless pit that could never be given enough to fill her. She was just so empty and so disturbed. I think her disturbance was very infectious.*

A number of participants talked about feeling drained, tired and depleted by these emotional experiences:

*P10: 636-640*

*I: What do you think wears you out about it?*

*P10: I don't know it's just the emotion that you give out, I think it's about you're giving out a lot, erm, of yourself, and I think it's important not to let the barrel get empty.*

*P07: 229-232*

*It made me tremendously tired. It really kind of, what I tend, I guess if I'm struggling with anything I do get tired [laughs], so that's the first barometer that things are affecting me when I get tired*



P05: 693-696

*I feel worn out. Many weekends I feel completely washed out, worn out. Emotionally drained sometimes and I think that impacts on your life. It impacts on your personal life.*

Two participants, who referred to a need to eat after seeing particular clients, also conveyed the feeling of being emptied or depleted, again suggesting the operation of a 'feeding' process:

P07: 504 -505

*Because there was a period of time when I felt absolutely starving afterwards*

P04: 461-464

*I think on a day to day basis it was just more a case of discussing with my, you know with people in the team and erm, increasing my chocolate intake, which is always the difficulty with seeing kids [laughs] with eating disorders.*

### **5.3.3. Exposure**

This sub theme relates to participants being exposed to experiences within work that seem to lead to quite unsettling changes to their perceptions of the world. It is as if what is put into them within these encounters leaves an indelible impression or mark. For two participants, this 'exposure' leads to an anxiety about their own children's safety, while for P07 and P03 there is a very visual impact to this exposure. P07 powerfully highlights this experience, feeling as if she is actually being made to witness child abuse in a session with an adult client:

P07: 206-210

*It was, because she was regressing to a child, she could see a child and she talked to a child of three erm, she was very vivid in her description and I saw the child of three being abused, so do you know, it was extremely vivid.*

P07 goes on to talk about the images of this witnessed abuse 'remaining' with her, as if they have become part of her memory system.

P07: 143-149

*I: Um hmm, because you said before you found it quite harrowing hearing about her experiences. Would you feel able to say any more about that?*

*007: I think it was, I suppose the detail..because she was experiencing them as they happened she needed to go into the detail of them and erm, if you see things in pictures like I do, those pictures remain with you*

P03 talks about a similar experience of having her 'eye opened'. This description has a torturous feel, as if she is being forced to see something against her will. The participant seems to feel exposed to the brutal realities of life, which had been kept abstracted, 'out there', but which are now brought into her awareness and become preoccupying:

P03: 213-225

*003: Um, hmm, so there was an eye opened to, you know, this is what a picture of what a child who's been abused can be and not the very superficial picture I maybe had in my mind and my thoughts. You know, I think I maybe had a preconceived idea what an abused child might present like and here, oh my god, this wasn't it! [smiles]. So there was a reality, a reality.*

*I: And kind of having your eye opened to that, what was that experience like?*

*003: I think it scared me. I think it really scared me. It really made me think about the really bad stuff er, part of that preoccupation was 'oh my god, this stuff really goes on out there'*

There was also a sense of this exposure causing a long-term reduction in reactivity to 'shocking' experiences, a 'baseline' shift. Participant 07 compares her 'therapy' world to the 'normal', mundane world of the 'average Joe', emphasising the distance between them.

P07: 169-179

*In the normal world, you know, if you work in Tesco you don't get that [laughs] kind of..and I think possibly my..in the jobs that we do, and in social work jobs as well, the base line for acceptability is higher, I think. . I think that's why sometimes kids can tell us things and you know, it is shocking but, you know, it's placed in the context of their family, but for the average Joe that would be mind boggling but I think that, baseline for me is quite high. So for me to be affected by something it has to be fairly powerful.*

This idea of inhabiting an 'otherly' world is also echoed by P10, who describes feeling different to people who are not part of the profession and thus do not seem to

be able to understand her experiences of work. A sense of contamination seems to run through and unite these experiences.

### **5.3.4. Acting in the present**

For two participants the client seems to continue to exert an emotional influence in the present (within the interview) something that is experienced strongly by the researcher as well as the therapist. This is explicitly acknowledged by one participant (P03) but is perhaps also reflected more subtly in increasing hesitancy, confusion and loss of concentration when talking about emotive aspects of these cases. It is notable that both of these participants are describing cases of child abuse (both sexual and emotional) and it is these cases that appear to have an ongoing influence, in contrast to an absence (at least at such an explicit level) of this experience within the other interviews.

*P03: 207-28*

*There was something about the level of erm...just something about the level of badness and evilness that she'd had to endure that made being around her really tough. I've forgotten what you asked me again.*

It is noticeable that P07's account becomes uncharacteristically hesitant, ending in her changing topic to comment on something more positive, perhaps as an attempt to avoid thinking about the images:

*P07: 143-153*

*I: Um hmm, because you said before you found it quite harrowing hearing about her experiences. Would you feel able to say any more about that?*

*007: I think it was, I suppose the detail..because she was experiencing them as they happened she needed to go into the detail of them and erm, if you see things in pictures like I do, those pictures remain with you erm and some of them you know were, were, it was..I mean I really admire her to, to, her resilience, to cope with what she coped with, but she had a lot to cope with... erm*

P03 goes on to comment, albeit it accompanied by laughter, on how difficult she has found it talking about her experiences:

*P03: 546-550*

*I: I was going to ask, and this might be hard to answer as well*

*003: [interrupts] You're going to have me crying before the hour's out.*

*I: Are you okay?*

*003: [laughs] Aye, I'm fine.*

#### **5.4. Theme two**

##### **The person and the professional: me, the therapist and the whole being**

This theme is represented in all participants' accounts and conveys an apparent tension or struggle between aspects of the therapists' personal (or non-therapist) and professional (therapist) self-identities. It is as though the perceived boundaries or membranes between the sense of personal and professional self become pushed and pulled within these therapeutic encounters, or as if the membranes become more permeable, letting more of the 'me' into the therapeutic encounter or letting more of the therapeutic encounter into one's 'personal' world.

P03, in commenting on the process of the research interview, conveys this sense of tension well. There seems to be confusion between the idea of personal and professional feelings, as if the therapist is now questioning her conceptualisation of the separation between these realms and whether there is indeed any separation:

*P03: 969-977 [lines suppressed 970-971]*

*it has been harder I think than I expected it to be, yeah, yes... but I think you can talk about your feelings about your job, but... maybe I was just thinking very professionally about it rather than personally, as if maybe the feelings didn't belong to me personally but they belonged to me professionally, I don't know. But aye, it was quite, quite shocking to experience some of my own feelings when you were asking the questions.*



### **5.4.1. Emotional me and the rational therapist: movement between roles**

A number of participants described a sense of bringing one's personal self, a role that is normatively kept outside the therapeutic setting, into the therapeutic encounter. For some therapists this seemed to lead to a sort of tension or questioning about the appropriateness of this movement.

P04 describes the impact of a particular client on her professional role, feeling that this particular case necessitated a 'break away' from her usual therapist role in order to facilitate engagement with the family. Her laughter at this point could perhaps indicate an underlying tension around this role shift, something she later says that she perhaps 'should' be uncomfortable about.

*P04: 58-69 [lines suppressed 65-67]*

*...we had lots of involvement over, over a five month period, where I saw them at least weekly, probably twice weekly most of the time, so it would have been quite a, you know, a good therapeutic relationship but also in terms of just being able to just be you, rather than the therapist [laughs]. So I think that was sometimes what I did as well, was trying to break away from the therapeutic role or therapist role rather.*

*P04: 728-730*

*I'm not really uncomfortable with it but in a way I feel that I should be uncomfortable with it. That's..perhaps being uncomfortable with it [laughs].*

P08 also talks about using 'herself' in therapy and comments that she has used 'herself' more with this particular client, with whom she has made a 'link':

*P08: 629-633*

*There was still a, a difference. Yeah it does, that's the link, that's how it affects you, you do use yourself a lot ..that's how I feel.*

*I: Use yourself..how do you mean?*

She goes on to say that using 'herself' or aspects of her personal experience, allows her to empathise with the client:

P08: 634-636

*Well I think its hard not to ...I use myself in therapy quite a bit anyway, about how things impact on me because that helps you to perhaps understand how somebody might be feeling.*

P08 goes on to suggest however, that there is a 'contradiction' between the 'uninvolved' 'professional' and the 'emotionally involved' human being, who at times becomes affected by the emotional pull of the client. Again there is perhaps an unacknowledged tension in this admission, with the participant feeling she would 'challenge' anyone who did not admit to this happening.

P08: 198-210

*I guess as a professional I'm aware that there is, well I think there's different schools of thought isn't there? (um hmm) but there's that bit about, you don't become too involved, you're doing your job, you be supportive but it almost feels like a bit of a contradiction, it's as if you can be supportive, empathetic, you know, sympathetic all the, buzz words and not become involved, emotionally involved and I think, I think (hmm)...that there are certain people that you work with that affect you in that way and I would challenge most people to say that that doesn't happen for them (um hmm), because it doesn't happen with everybody.*

The idea of there being a conflict between a more 'rational', detached self and an emotional self is also conveyed in other accounts. It is as though the professional rationalising and sense-making is unable to counteract the emotional impact of the work, leading to a residual self-doubt, something that remains active at the 'back of the mind':

P04: 433-437

*at the back of my mind..there's always the doubts that you know, could I have done something differently? And I think, being very rational about it, I think not, but erm..I'm not always very rational [laughs] erm...*

Similarly, although P09 'knows' intellectually that she is not a 'monster', she continues to *feel* like one and questions her practice when her client casts her into this role:

P09: 547-550

*And I knew it was nothing to do with me, it was her projection but I thought, 'Oh God, did I go too fast' so, that was, that was a bad one, I really did not like feeling like a monster [laughs].*

For other therapists, the tension between the emotional and rational was expressed more explicitly in terms of powerful maternal feelings. P07 for example, discussing a former aspect of her role, indicates a tension between the 'mother/person' part of self and the constrained, professional self:

P07: 194-197

*... and sometimes they are child protection concerns and part of you as a person and as a mum thinks 'that's wrong', but you, you know, you have to accept that because of the contingencies of the agency or because you know, you can't remove every child with heroin abusing parents for example, but that's not accept, you know, on some level that's not acceptable.*

The impossibility of remaining a 'rational' professional is illustrated well by P03. There seems to be something about these children that again touches her humanity. The tools of the trade cannot seem to protect her from this impact, which cannot be 'supervised' or 'processed' away:

P03: 330- 336

*no matter how much supervision you have, and process, how much you talk about, think about and process what's going on, if you're sitting looking at a kid who's got nobody to go home to that loves them it's, it's painful, you know. Because that's what we all want. We're all human beings, we all search for that.*

In a similar way, P09 also highlights the emotional intensity of sitting with a child whom she as therapist cannot 'reach with words':

P09: 569-581

*I mean the girl got to me altogether because when she was upset she'd be incredibly sad and wanting to kill herself and seriously seriously low erm and, she didn't have anybody in the world really and [4] she would be sitting there just **desolate** and there would be absolutely nothing you could do, because as she put it 'stuff that had happened to her', and you know, sometimes I would kind of say, because she couldn't speak about it and you couldn't touch it with words erm, I mean at one point*

*I would sort of say 'could I have permission to hold your hand?' or something like that...*

In the following extract, P03 talks about a child she is working with going into hospital for some emergency medical treatment. This is discussed in the context of the child seemingly being abandoned and uncared for by his family at a time of acute need. In narrating this situation, P03 makes an apparent slip of the tongue, perhaps revealing the intensity of her empathy towards this child, whose basic need is to be loved (to form a 'heart to heart' connection) rather than anything the 'professional' therapist can provide:

*P03:370-373*

*...and he needed fairly aggressive resuscitation, not heart to heart but just kind of rehydrating him and getting his fluids back up*

#### **5.4.2. Confronting 'other' aspects of self**

This sub theme is represented across all accounts and relates to the participants' descriptions of encounters with less desired, hidden or vulnerable aspects of their inner experience within the therapeutic setting, something that perhaps feels incongruent with the therapeutic role or threatening to the professional self:

*P03: 645-648*

*And by that I think I mean some of the hairiest cases I've had, scary angry people who make you experience anger at a level that you hardly know exists in yourself sometimes.*

Participant 003 describes getting in touch with powerful, 'raw' emotions. These are experienced in response to encountering a child who has been sexual abused:

*P03: 25-31*

*Erm, I think my experience was very primal. Is primal the right word to use? I think I had a really sort of primal... reaction to the child, I think really quite.. raw reaction*

*to the story ....and probably hearing the story is... I can't remember how I heard the story, what the powerful way was, I think it was another worker sharing the story from the notes.*

P05 also experiences 'raw' emotions during clinical work with a particular client, but for her the rawness is seen to relate to the case touching upon personal experience rather than as a reaction to the details of the client's experience:

*P05: 139-142*

*some of the sessions were extremely difficult for me because you know, I think my emotions were a lot to the fore, whereas really during sessions you wouldn't want them to be as, as, feeling as raw as that you know.*

Other participants described feelings of envy towards the client, whose problems seemed to have some personal resonance for the therapists. Again these feelings are experienced as being 'primitive' and perhaps also felt to be professionally undesirable, as implied by P05's repeated indication that she is being 'totally honest', followed by an assertion that this did not 'get in the way' of her professionalism:

*P04: 189-202 [lines suppressed: 192]*

*I: And when you said you didn't like working with people with eating disorders before, can you say a bit about that?*

*004: I think there's issues that I've probably not resolved around, around eating completely in myself [smiling]. Erm, and...when you are on the other side of the fence with weight you probably think, hmm that's not so bad, I probably, there's a bit about me that would like that slight bit of control, never, never as much but I wouldn't mind not being able to eat for a day [laughs], probably not for months at a time but I think there's, you know, that sort of, at a very primitive level that.*

*P05: 179-184*

*005: I think if I'm honest as well, there might have been an element of envy as well..if I'm being totally honest.*

*I: Right, hmm.*

*005: If I'm being totally honest because I didn't get any help even though I asked for it..erm. I don't think any of these feelings really got in the way.*



Similarly, in concurrence with a theme of feelings being drawn from the ‘depths’ of therapists’ inner experience, there was a feeling of personal issues being ‘resurrected’ by work with particular clients. For P10 this is experienced as helpful, seeming to facilitate empathy while for P05 this is a more painful process:

*P08: 642-648 [lines suppressed 644-645]*

*Yes, it resurrects things in yourself doesn't it, it does, it makes you reflect and brings up memories and there's similarities in that [words removed] ...and some of the difficulties that she has encountered in that relationship are similar to the difficulties I experienced in my relationship, so there's a connection there and there's a sympathy there and an empathy there*

*P05: 60-62*

*It did at the time have a real impact on me because it made me revisit some of those feelings that I had and made me question myself as a parent*

There was a sense of many participants feeling incompetent and incapable within their professional roles at times, again challenging the professional identity. For P05, these feelings stem from the case resonating with personal struggles, while for others, the complex nature of the cases perhaps can be seen to deny participants’ personal need to feel helpful or competent:

*P05: 91-99*

*I: What were your..I don't know if they were fears but what were your concerns before taking it on?*

*005: I guess my concerns were like 'who the hell am I to be taking this on?' [laughs], you know, when I haven't managed it, [words removed], I haven't managed it so how am I going to manage it for somebody else. That was my fear that I would let somebody down, that I wouldn't be able to do the sort of therapeutic bit that needed to be done*

Similarly, for P06 a feeling of therapeutic uncertainty seems to lead to her feeling ‘clueless’ and unable to carry out her therapeutic role:

*P06: 27-31*

*... his parents, I think were really struggling with this boy who was very difficult, his behaviour was very difficult. Erm and I hadn't a bloody clue what I was doing. I hadn't a **clue** what I was doing with this boy.*

For P09 this experience extends beyond uncertainty; there is a sense of the therapist being publicly shamed by her client, who represents her as being 'inhuman', something so extreme that it leads her to question her own identity:

*P09: 590-595*

*she sort of turned on you and said 'you're a monster' basically, I mean she was pretty vicious about that she said about me and told everybody else, you know, what an awful woman I was.*

*P09: 604-611*

*I became that monster and it's so the opposite of how I experienced myself and thought about myself but then I began to wonder 'well really am I?' was I sort of abusive to her, did I push her too far, did I not realise the full depth of how awful her inner life was and..I just er oh, you know, that was the kind of thing that went on in my head [smiles].*

On a more explicit level, there was an awareness from many participants that there is an element of personal gain or gratification for them within the work, something which again perhaps challenges the altruistic professional identity of self as 'helper' and appears to be associated with uncomfortable feelings, indicated by the smiling, laughter and whispering accompanying these sections:

*P03: 228-245*

*Thinking back, I think just the sadness, the absolute sadness and shock (hmm), about what we were dealing with. But with that, and this is a kind of horrible thing to talk about, but with that there was a bit of an unhealthy buzz I think and maybe that was er, I don't know, maybe something about the neediness..and something about thinking 'well I've got a job to do here to work with this neediness'. So I think for a small chunk of time there was a compulsion in me to sort something, a compulsion in me to fix something, to make something better, that was probably a pretty unhealthy compulsion as well. But I think in response to what, what I was being faced with...and there's no doubt personal stuff figures into that as well, you know I think erm, that kind of personal need to fix something and feel that you're doing a good job or need to make somebody else better...is driven from the deepest darkest innards of oneself [smiles] [4].*

*P07: 552-556*

*I also really enjoy it, which is sometimes, I think really quite perverse [laughs], but I do learn new things about myself through the work as well. Erm, some things I don't like about myself, I mean its not all great believe me.*

P04: 384-387

*If I have a sort of day that's clinic, you know, full of appointments like that, I do end it on a little bit of a high. I do have a little bit of a... [whispers] I'm addicted to seeing patients [laughs].*

### **5.4.3. Role reversal: becoming the 'patient'**

This sub theme relates to a description in many participants' accounts of a sense of experiencing the continuum between 'madness' and emotional vulnerability, of the therapist seeming to feel that the 'rational', professional self has been temporarily lost, altered or even broken by aspects of the work.

At the milder end of this experience, there is an increased awareness of emotional vulnerability, shown for example, by P05 and P09, who become aware of their own need for support at times. This can be contrasted to the more dramatic accounts of P03 and P06, shown below.

For P03 there is a sense of her professional boundaries being permeated by her feelings towards a child, whom she considers taking home, despite an awareness that this is against 'normal' convention:

P03: 282-288

*you know at the point when I was seriously considering doing something more was at a point when...[exhales] he was sixteen and do you know, what normal person would consider taking in a sixteen-year-old male teenager [laughs], do you know, it was madness, it was complete madness and kind of bonkers stuff going on.*

This can be contrasted to P06, for whom the sense of 'madness' comes from disharmony within the team, yet ultimately 'infects' her, leading to a period of sickness for her:

P06: 446-453

*It felt mad, it felt like there was a madness around. And it wasn't your patients (laughs). It was a kind of uncontained erm... it **was** mad, it **was** mad. There was a*

*madness around that you couldn't address, you couldn't help, you, couldn't do anything about, nobody could do anything about it. Aye it was pretty horrible actually, it was a horrible time.*

Two participants related experiences of becoming unwell at work, resulting in a temporary giving up of the therapist role:

*P07: 660-666*

*I really recognise that I was quite unhealthy doing that work. I suppose because I **did** become ill, there was one day I just couldn't go back to work and that's the only way I could describe it. I had my jacket and my car keys in my hand and I just could not walk out of that door and I ended up being off for five months.*

*P06: 169-175*

*Erm, I think it was just a really difficult time and I think it wasn't solely to blame, but I think that it contributed to my, just, not feeling I could do this anymore. And I had to go off sick because I had a kind of post-viral thing but looking back at that I think it was a whole lot of stuff and I think a lot of it was feeling quite burnt out with cases like this and stressed and not coping*

#### **5.4.4. Taking work home**

Seven participants described experiencing shifts in established boundaries, leading to a tendency to take their work home with them. The following extracts illustrate the many facets of this experience, where work is taken home in the form of thoughts, emotions and dreams. In the following accounts this is conveyed as a sense of anxiety about the clients' well being in the present rather than a re-experiencing of traumatic aspects of the client's past, as conveyed by P07.

*P03: 71-91 [lines suppressed 74-81]*

*I: And would you be able to say a bit about what effect that had on you?*

*003: I think I kept the wee girl constantly in my mind, sort of in work and out of work.*

*...this wee girl was just constantly in my thoughts and how she was living, really feeling for her situation was preoccupying my thoughts.*

P10: 333-337

*It's when you're lying down it catches up with you. You think that you've coped with it and you think that you've been ok and then when you lie in bed... you think 'this is a bit worrying and I hope they're ok.'*

P04: 302-308

*And the night before I saw her I was dreaming about her..I can't remember the dream fortunately but it was that bit of [laughs], you know, and just dwelling on it much more and erm..being tempted to phone the hospital more often to check 'are they okay'..but I haven't done that much [laughs]...so just a sense of concern..slight worry [laughs]..*

For P05, there is a slightly different feel to her taking work home, something she is forced to do because she feels as if she is not permitted to have the feelings during her busy working day. This will be commented on in the discussion.

P05: 278-281

*So it was all those sort of feelings I couldn't afford to have in the workplace. I couldn't afford to have them while I was here, so I had them when I was at home and that was quite hard.*

This can be contrasted to P03, for whom taking 'work' home extends into a literal desire to take a child home, which seems to represent an need to do something more, to break through rather than extend the boundaries:

P03: 271-288 [lines suppressed 279-285]

*Not so very long ago there was a young boy that I'd worked with for a long time, who provoked probably the strongest feeling that any child has ever provoked in me, in my entire career, but at a point where I was much more experienced and kind of knew what I was a bout erm, but he provoked strong enough feelings in me that I would have taken him home...and I even talked with my family about taking him home at one point... what normal person would consider taking in a sixteen-year-old male teenager [laughs], do you know, it was madness , it was complete madness and kind of bonkers stuff going on.*

For other participants taking work home also related to the manner in which the 'therapist' role infiltrates home life. A number of participants talked about the



influence of their work on parenting and on wider relationships. For P03 and P05 this translated as a fear for their children's safety:

*P05: 217-226*

*I remember when I was training [words removed], I was on a placement in a project which only dealt with erm..er, sexual abuse, child sexual abuse. And that was the first time that I've really experienced how your work can really impact on you as a parent, cos it stopped me allowing my children to do anything. I wouldn't let them do anything and I had a real period of adjustment because it just makes you realise the dangers that are out there. And I had to really erm, well my husband helped me work through that, you know, to be reasonable.*

*P03: 586-595*

*I've come across kids that have had terrible experiences and if there's a negative thing, I know I know I know [to emphasise] when [name of own child] was younger there was days I used to go up the road and wouldn't want to let [child] out of my sight. D'you know that, in terms of what emotions, how the, what emotions were pulled out of me. Kind of recognising the bad things in this world and [child] would still say to this day that I'm a nervous wreck [laughs]..*

These anxious experiences can be contrasted to P08's account of the perceived gains in her relationship with her children due to her work:

*P08: 761-767*

*So on a personal level it has definitely helped me to think about how I engage with and think about my children, you know, an awful lot more. It's not only that it's about how I help **them** to think about their emotions more (right); I think that's also very key. I'm more able to get them to think about their emotional world.*

## 5.5. Theme three

### Responsibility

The theme of responsibility was strongly present across all participants' accounts with one notable exception (P09). Comment on this exception is given at the end of this section. The overall theme encapsulates an impression of the therapists feeling a strong sense of responsibility for these particular clients, leading to an anxiety about being unable to help the client, or a fear that by their action or inaction, harm will come to the client. This theme is played out in complex ways within participants' accounts, with participants explicating many different facets of responsibility.

#### **5.5.1. Holding on and letting go**

Seven participants described aspects of the experience of 'holding onto' clients and 'letting go' of clients. The experience is particularly strongly described by P03, who seems to feel responsible not only for the clinical care of her client but also conveys a sense of becoming a 'lifeline' for a very troubled young person:

*P03: 458-463*

*I knew I was walking away and leaving him in a poor situation and I think I would fight more. If I were in the same situation again I would fight more and fight harder. ..to keep somebody alive because at the end of the day I think that's what it was about. It was about keeping somebody alive.*

The description gives the impression that P03 is metaphorically holding on to the client, who seems to be in a precarious position. In this particular case the therapist feels unable to 'hold on' any longer and 'lets go' of the young person, who moves into adult mental health care. The subsequent death of this young person some months later has left the therapist with a permanent burden of guilt, a 'big bag of potatoes' worth' (P03: 308).

P03: 424-441 [lines suppressed 432-434]

*There will always be an anxiety that I'll need to experience the loss of another young person erm, although it's not my fault, I don't think. Actually that's not true. At the time I felt very responsible and very critical of myself for losing a kid, erm and angry I think at myself for.. letting go. Actually I think maybe if I'd hung on you know, a wee while longer, I'd have achieved something better. [section suppressed] I think what I've learned is that it was the wrong thing to do. [lines removed] He may have been over 16, in fact he was nearly 17 when he died er [clears throat] but I should have kept hold of the case for a bit longer...*

P04 also highlights the life and death nature of her role, having to decide whether an at risk young person needs to be compulsorily admitted to hospital that evening or not. Her laughter here seems to convey a tension around the enormity of this task and perhaps a feeling of absurdity that she is the one to decide:

P04: 269-276

*[I] spoke to the social worker who said, you know it comes down to do you think she's going to die tonight or not? [laughs] And yes, you know, she could. In all likelihood she wouldn't but she could and you know, the thing that you decide whether that's right or wrong..the chance is really really slim but whether something would happen **tonight** or not you know, any other night. And if it does, **you** made the wrong choice*

In relation to another clinical case, P04 describes her inability to 'switch off' from the case, where a young anorexic client has been admitted to hospital. It is as if there is a responsibility to keep this young person in mind, with the 'switch' perhaps connoting a feeling of being a life support to the young person:

P04: 126-133

*You do think about, unfortunately I do think about them. I used to be much better at not thinking about people [laughs] when I first, when I had erm, but recently I've not just been able to switch off and not think about it but I think that er, you know, when you're seeing people that frequently it is very difficult to just walk away from it.*

P04 goes on to say that she has, unusually for her, kept her mobile phone on in the holidays, asking her colleagues to contact her about this case. Again this seems to highlight the fact that she feels unable to 'switch off' from this client:

*P04: 491-493*

*I normally wouldn't keep my mobile on in holidays but this time, if I hadn't seen it for a day I would go and see if there were any missed calls.*

This experience of needing to 'hold onto' the client is conveyed within other accounts in slightly different ways. P07 describes a feeling of responsibility for not 'letting down' the parent she is working with by handing her care over to adult services. Again the language use pertains to 'holding' and protecting the client in some way, conveying a sense of being compelled to honour the link that the client has made to her, despite the anxiety this engenders:

*P07: 48-56*

*"I was worried that she was becoming very ill so I spoke to her GP and again spoke to the team but she was very clear that in a sense, she had made a link, or she had started to engage with me and she wanted to continue and I think... there was a lot of pressure, not pressure, but you kind of don't want to let someone down when they're so obviously in need, so I was very aware that I was, particularly [makes sighing sound]..I suppose not sure of what was coming next"*

P07 also goes on to indicate a fear of her client 'fragmenting' or of the client's family, 'disintegrating', again suggesting that the therapist feels she is in some way 'holding together' her seemingly fragile client:

*P07: 255-256*

*And I think I was thinking, is she totally fragmenting, is she just going to pieces*

*P07: 296-301*

*I: And what was the anxiety about?*

*007: [sighs]. Her probably falling ill I guess, because if she fell ill, you know, she would have to be hospitalised and so her kids, the relationship with the [extended family] wasn't so good, so the whole family would have disintegrated and so I think that was quite a burden to carry at times. I just felt there was a pressure to make her better...*

P08 describes her experience of working with a vulnerable parent, who is working through some traumatic experiences. The therapist once more seems to be 'holding' the client, again with a connotation of the client being in a precarious position:

*P08: 300-304*

*I suppose there is a sense of that (um hmm) and a sense of knowing that, I'm holding her there so you do question and it is scary but fortunately in addition to my colleague I also have my [specialist] supervision group, we have a consultant, so I feel as if I'm supported.*

These experiences of 'holding on' can be compared to P06 and P10's accounts of the importance of being able to 'let go' of families. For P06 the permission to 'let go' is granted by her team culture, whereas for P10, her acquired 'ruthlessness' in letting go is contrasted to her team colleagues, whom she feels tend to 'hold on' for longer.

*P06: 255-265*

*I think when I came back there was a different culture around which has been very difficult in itself, but I think it's been a healthier culture because... and okay call it medicalised, call it what you want but I think it gives you, there's much more permission to let go of families. To not hang on, and hang on and hang on with these really difficult families where you've reached a therapeutic ceiling. Can't go any further, can't tell them any more, can't offer any more. So there's a kind of permission I think to let these kind of families go erm...*

*P10: 925-931*

*I would have closed a lot of the cases a whole lot sooner [in comparison to colleagues] so maybe you develop a kind of ruthlessness in saying: 'no you're not doing anything, they're not wanting to come just now, you know, you've tried to engage them, you've done your best, let it go'.*

### **5.5.2. Fear of doing the wrong thing**

A number of the participants describe the difficulties of managing therapeutic uncertainty with these clients. There is a recurrent sense of therapists struggling to navigate an unmapped therapeutic terrain, with clients who provoke high levels of



anxiety. There seems to be a fear of harming the client, of missing something or of making the wrong choice, which appears to lead to a need to do more for the client. P07 describes this struggle particularly well:

*P07: 334-348*

*Because I've not done psychoanalytic training to that degree so should I be even attempting to kind of..you know, there was times when I sort of thought 'ohohoh, what am I doing? Am I making her worse?' Erm.. I guess when people are ill, its not like a kind of erm, a broken leg where you can see if it's, do x-rays and see if it's getting better every week and say 'oh look, it's healing it's healing'. You don't know if someone is healing. You also don't know if they're telling you everything, so in the kind of weeks where, I used to see her fortnightly, I wanted to see her weekly to make sure I kind of had a short period of time to make sure that she was indeed coping and I guess..that was a bit about just feeling..really anxious.*

P04 also describes her struggle with uncertainty in the therapeutic process, wondering whether she could have done anything differently to stop a very needy client from disengaging from therapy. She seems to take responsibility for the disengagement, leading to a questioning of her practice:

*P04: 183-188*

*There's lots of other factors in their life as well that contributed but there is something as well that makes you think 'is there something that I could have done differently?' Erm, given them more support or if you had been able to do x, y and z would they have been able to maintain their coming?*

For P10, this experience of uncertainty is characterised by anxiety about her clinical judgement as to whether a young person who has self-harmed is safe to be sent home. The therapist is aware of her inability to control the volatility of the girl's home situation and that there are no guarantees about whether she has made the right judgement or whether she might receive the 'phone call', an anxiety which seems too difficult to speak out loud:

*P10: 63-70*

*But erm it did make me very aware, oh this girl is really is very vulnerable and erm... you know it leaves you with some level of anxiety. Erm...and aware of the*

*volatility. I'm sure if she goes out of here and has a perfectly calm experience, you know goes home, has some pleasant time with her friends, she'll be fine. But you're aware that the acts are all very impulsive.*

*P10: 267-272*

*I'm worried that when I go in on Monday or the next morning am I going to get a phone call to s.. [stops mid-sentence] you know and sometimes they have ended up in hospital or have been taken to accident and emergency for some treatment.*

The fear of something 'going wrong' is further manifested in references P10 makes to 'hoping to god', 'saying a prayer' and 'touching wood', as if to emphasise her lack of control over the girl's situation, yet interestingly she nevertheless feels responsible for the girl's well-being, lying awake and thinking about her at night. This appears to be a paradoxical bind; feeling a weight of responsibility and yet having no means to prevent the young person from harming herself, as is illustrated in the extract below. It is interesting perhaps that the participant here apparently makes a slip of the tongue, correcting 'protect' to 'prevent', a distinction which perhaps underlies a conflict between her desire to nurture and 'protect' the young person (and perhaps owning a parental sense of responsibility) and her more clinical, detached duty of 'prevention':

*P10: 238-250*

*I: When you talked about it being, kind of, anxiety provoking with these sorts of young people, were you thinking about responsibility or are their other things...*

*010: Well you're frightened for their safety. That's the bottom line you know. You know that you can't protect [corrects self] prevent people from killing themselves or hurting themselves seriously but you know, you want to do you best and if you feel they're severely at risk, try and make sure that there's people gonnae be around them just to make sure everything's ok. Well, as ok as you can make it.*

### **5.5.3. Shouldering a burden**

This sub theme of responsibility is present in a number of accounts, and seems to relate strongly to the sub theme of 'holding on and letting go'. The theme is

characterised by the participants sensing their importance to the client and feeling as if they alone are responsible for the client's well being. For P04, this is characterised by feeling like she is 'the shoulders' carrying the responsibility. For P08, this is particularly strongly communicated and appears to be linked to the client's expectations of her. The issue of the client placing 'trust' in her is pertinent to her. There is a sense of the participant becoming aware of her importance to the client, feeling as though she is the client's 'axis'. This appears to be a position of both privilege and burden:

P08: 228-237

*That's always there, that's your duty of responsibility anyway but it just feels even more so, because that person **trusts** you. I think there's different degrees of trust (um hmm) isn't there, in a relationship, because I would say I have quite a trusting relationship with a number of my clients but then (hmm), not to the same degree. People share such a lot of themselves and take risks with you..I think that feels like quite a privileged position. I also think it feels like a very trusting, so by Christ I better get it right [laughs]*

P08: 681-685

*I: Um hmm, and you said they expected something, what do you think they expected of you?*

*008: That I'm the axis if you like, I'm sure there is the idea that this person's mine, that I'm going to make them feel better at the end of all this.*

For P04, part of the burden comes from the progression in her career to a more senior role, where she has greater responsibility:

P04: 233-246

*So it's not that you work without responsibility but I think it's more that sense of there's somebody out there that you can ask and they make the decisions about it, that erm, you know or they shoulder the decisions really. And then coming to a stage where you are that person's shoulders.. [laughs], carrying the decision and the responsibility.*

For other participants, the burden of responsibility also seemed to link to the client's expectations of the therapist, expectations that are either unrealistic or which feel unobtainable:

P07: 364-367

*I mean I'm working with two wee kids who were in a post-adoptive placement and it was almost like 'well, if you fix them we'll adopt them' [laughs]. I mean, how does that work!*

P06: 142-153

*[the parents] were looking to **me** to advise them and I couldn't because I didn't know so I felt very dumped by this. I felt very dumped by this [cut 145-151]. I felt **totally** at sea with it. Totally at sea with it.*

For P03 the expectations come from the child, who is in a desolate situation and appears to perceive the therapist as a potential parent:

P03: 298-299

*... there was no one who cared for him, no one who cared for him in the world..*

P03: 322-325

*I've become to them something that they don't have anywhere else in their life and it's someone who listens, someone who cares and someone who in their mind can potentially become a parent to them.*

#### **5.5.4. Negotiating Responsibility**

Five participants made reference to a need to come to a balance, or to re-negotiate the parameters of their responsibility for clients. This was sometimes characterised as a struggle between a rational, detached self and a more emotional, 'rescuer' self. This is illustrated well by P10, who describes a need to boundary her 'rescuer' tendencies:

P10: 771-774

*I would be concerned at times I'm too much of a rescuer and that's when you need to get boundaries and I don't think I always get it right.*

For P10 the way to boundary this tendency is to consider her role within the wider network of supporting professionals:

P10: 525-531

*I try and make sure I'm doing the best I can and that I'm doing enough and if I'm not doing enough I know where to get extra help, you know. You know, don't hold onto things that's not your private possession, it's not your problem it's up to you to get people the best help they can get. And if that's elsewhere, get it.*

For participant 06, the negotiation of responsibility is a key feature of the narrative. She explains her need to redefine her own boundaries for responsibility in the wake of an illness experience, which she describes as becoming 'burnt out'. For her, the key aspect of this experience is in handing responsibility back to families and other professionals rather than endorsing an 'expert' role:

P06: 171-184

*And I had to go off sick because I had a kind of post-viral thing but looking back at that I think it was a whole lot of stuff and I think a lot of it was feeling quite burnt out with cases like this and stressed and not coping. So when I came back what it did to me was when I came back from being off sick, was I needed to be **much** much clearer about the kind of families that I was going to see, the kind of work we were gonnae be doing. Erm I needed to be much clearer about the kind of remit, of the work, looking at who we were going to see, what kind of cases we were going to see and... much clearer that if I was really struggling with a case I wanted to pull other people in, I wasn't going to soldier on and be brave, because that's what you did[laughs].*

P06: 277-283

*It was really helpful for me coming back and just, I think being a bit less precious and thinking that...you know, you're families won't survive without you [mumbles laughing] ... well actually they bloody will [laughs] you know! And I think also realising that you've got limits as a clinician and you can't cure everything and fix everything [10].*

Similarly, P05 talks about a recent feeling of fatigue at work and has been considering the limits to her responsibility. However, in contrast to P06, there is a sense of this being an unresolved issue for her, something that perhaps creates a tension between her need to do her best and her need to protect herself:

P05: 730-743[lines 738-741 suppressed]

*I've been thinking recently that maybe I need to not be so erm...needing to feel that I have to give the absolute best to every single case you know. Erm and I think [in previous role] I got very worn out because I treated every case the same. [lines suppressed]... And maybe actually now's the time to start thinking about actually sometimes you can't do that for absolutely every case and in some cases maybe you*



*have to relax up on that a wee bit and it's hard for me to think that way and I think that every case I work you need to give the same to each one but maybe..you know.*

P04 also seems to be debating this issue in relation to a hospitalised adolescent. For her this also relates to giving responsibility back to the client:

*P04: 325-330*

*...and I think I have moved away from a little bit from that and realised, you know, you can't be responsible for everything..I can't..I wish that I would have been able to give more support bla bla bla to the family to maintain her in the community but one, that might not have been the right thing but also..you can't be there the whole time.*

### **5.5.5. Comment on difference in P09's account**

P09's account differed markedly from all other accounts in the absence of the theme of responsibility and requires comment.

This participant described a love for her work, an enjoyment of the creativity of the work and a strong desire to be helpful to her clients. The following extracts give a brief flavour of this, however this will also be discussed in section 8.

*P09: 230-235*

*I just, realise how much I get out of it and what a kind of privilege it is. I love the fun of kids and I, I just find it so interesting how people relate and how people work and I just find it utterly fascinating and so I'm really aware of how much I get out of it*

It was notable that for P09, challenges within therapeutic work are not described as eliciting feelings of responsibility and burden but instead seem to be channelled into a very proactive learning strategy, a desire to know more and to go forward. The following description of a therapeutic impasse in working with an anorexic young person illustrates this:

*P09: 65-72*

*I've always been interested in developing therapeutic skills and I felt that she was an example of someone that we hadn't been particularly effective with. I didn't feel bad*

*about it, because clearly everyone else had been ineffective as well, but just kind of interested I suppose, it just sort of developed my interest*

There was a sense of the importance of learning and development for this therapist, as well as a seemingly optimistic, philosophical stance, which perhaps serves a protective function for this therapist:

*P09: 411-415*

*I: Hm hmm, what's the impact of those experiences, seeing those things, I suppose the more difficult things?*

*009: Erm [11], I suppose, probably a sense of being incredibly lucky really [8].*

## 5.6. Theme four

### Support

This theme was represented across all accounts and refers to the apparent need for all participants to be supported by others in order to cope effectively with their work. This support comes in the form of colleagues, managers, organisational culture and also friends and family.

#### 5.6.1. Importance of team support

There were several different facets to this sub theme, which highlighted the importance of team support for participants' emotional well-being. For several participants there was a sense of the team providing an important space for sharing and relieving anxieties about cases:

*P05: 295-300*

*I dealt with it by sharing a lot the thoughts that I was having with [colleague]. Probably not the real personal stuff, you know. I think I was able to say: 'this has got real parallels, I think she's probably feeling like this because that's how I felt'. And I was able to share my anxieties about taking on the case and the reasons why I had those anxious feelings.*

Similarly, for other participants, the importance of receiving backup and affirmation of clinical judgements was also present:

*P10: 217-221*

*I find doing the best way I can do the best I can is grabbing a hold of one of my colleagues and saying 'look, could you just make sure I'm neither over or under reacting here' and maybe think it through with them.*

*P05: 409-412*

*So she [colleague] was able to alleviate my anxieties and to put things in context and to be able to listen to what I was bringing out of sessions and say 'I totally agree with you, I think you're right, that is what you need to do.*

For P06 carrying out a shared initial assessment with another team member seemed to give her permission to admit uncertainty, rather than feeling pressured to provide answers. This seems to provide a sense of protection against the ‘exposure’ of individual work:

*P06: 835-844*

*006: You might do the ongoing work on your own, but the initial assessment piece of the task is shared. It just feels much more kind of supportive. And less kind of exposing I think.*

*I: less exposing?*

*006: You're less het. It's not just you that's seeing this. It's a joint point of view and also if you, if I don't know or are not clear or I think it might be something else I don't know.. and ... it feels all right to say to families now: 'I'm puzzled, I don't know.'*

P07, by contrast, highlighted the importance of the team understanding her need for space to deal with the emotional impact of a particularly demanding case. It is possible that this highlights something different about the nature of working with a sexual abuse case, where ‘support’ comes in the form of space rather than in the joining and sharing described elsewhere:

*P07: 525-533*

*I: And were you able to get that space?*

*007: Uh huh. I think I had to find it. I wasn't good at finding it to start with and then I realised I needed it, I needed to find erm... and again I think I was supported by the team to be able to do that, so if I did for instance go away early no-one was saying 'hey, where's she ..are you part time?' [laughs]. You know, I was able to think 'I'm shattered, I'm out of here!' [laughs] and that's okay (yeah) [4].*

Similarly, this sense of the team ‘getting it’, or being understanding of therapists’ needs was echoed by P10, who indicated that for her, the team seems to fulfil vital support needs, which other ‘lay’ friends can not seem to meet. Her use of the term ‘going through’ seems to highlight both an emotional toll and the ongoing, active nature of the emotional sense- making:

P10: 413-426

*it impacts on you so totally as a person I mean, I don't find that it's something you can talk about to anybody else who isn't in the job or related jobs. Erm, you know, I wouldn't talk about it to my family or I would talk about it to my friends who aren't in this line of work, erm... so I think you've got quite a small population you can talk to about it and mainly for me, that's my colleagues. I've got friends who are in similar line of work, you can acknowledge to one another that you're feeling under pressure that you're stressed, erm... but you don't actually go into the nitty gritty. But you know they understand 'cause they're going through similar things.*

For P09 the team seems to provide a sort of reality check, counteracting the clinician's unrealistic expectations and preventing despondency about being unable to bring about change with some cases:

P09: 252-258

*I guess one thing about working here is that the supervision and support you get in the team is great because I think you could kind of get sort of quite down about things, well I could get quite down about things because I would expect to be sort of curing all over the place [laughs], which is not how it works [4].*

Across the different facets of the 'support' experience, there is an impression of the team providing a nurturing, protective space for its members. This has a familial feel, which is further drawn out in the following extracts. For P03 and P06 there is a sense of the team, or certain team members, fulfilling a parenting function, taking an authoritative stance during times of stress:

P03: 670-676

*[name of clinician], if she were here would be able to share the story of screening me one day and in the break I said to her 'I don't want to go back' [imitating child like sobbing voice] and she said 'well you have to' [firm voice] and I said 'but I don't want to go back' [again imitating child's voice] but the mum was just foul and 'I can't stand her, I can't go back in there' [same voice] and she said 'well, you need to go back' [firm voice again] [laughs].*

P06: 421-433 [lines suppressed 425-427]

*Oh I think it was a **huge** sense of anxiety. I think it was a huge anxiety for the team. About how they would manage without [team member], who was very kind of paternalistic and you know [lines suppressed], erm, just kind of very gentle and... definitely the kind of lead of the team [line suppressed]... the buck stopped with him. Picked the bits up, took on a lot of the donkeywork and looked after people in*



*that respect. So I think there was a real anxiety about what would happen when he left. Erm, who would be in charge*

*P06: 315-319*

*And... I think what I was really wanting was somebody to say: "you need to stop seeing this. You cannae do this, we'll do it." Nobody did. And nobody offered. And... or nobody said I'll come and join you with it.*

### **5.6.2. Impact of lack of support**

Although present across several accounts, this sub theme was strongly represented in P06 and P07's accounts and highlighted the impact of a perceived lack of team support on therapists' emotional well-being.

P07 described feeling that a lack of support within a former job had been responsible for making her ill:

*P07: 661- 678 [lines suppressed 668-671]*

*I **did** become ill. There was one day I just couldn't go back to work and that's the only way I could describe it. I had my jacket and my car keys in my hand and I just could not walk out of that door and I ended up being off for five months. When I look back on that the organisation had the responsibility to me erm, that they failed, you know. [lines suppressed] I was the most experienced worker on the floor and everyone kept saying 'give it to [name of clinician] to do, because you know she'll get it done' you know, and it was a bit like 'hold on a minute!'. And when I went back after five months hardly anyone had done any of my work and you realise 'hold on a minute, what is this crisis about?'*

P06 described the impact of working within a team where there was considerable disharmony. The apparent 'fragmentation' of the team seemed to lead to a feeling of there having been a shipwreck, with every man looking out for himself. P06's account of this was replete with metaphors of struggle and battle at work, which provide a particular richness to the representation of this experience.

P06 reports feeling 'at sea', 'out of depth' and 'dumped' with a particular case.

References to trying to 'pull others [in the team] on board' convey an image of the therapist manning a sinking ship, taking more and more water on board ('soaking it up'), apparently without anyone else noticing as they themselves are 'caught up' trying to 'survive the team'.

*P06: 153 -171*

*006: I felt **totally** at sea with it. Totally at sea with it.*

*I: What were the effects of that for you?*

*006: Erm, I think it wasn't just that. But I think that there were other cases as well at the time. The usual, the kind of, hurly-burly stuff of working here, just difficult, families which I think, ...are probably all right but when I think there is a particular case that erm, I think that, I think that I just felt completely overwhelmed, out my depth, dreaded seeing the family erm... I think I just felt completely stuck, totally stuck. Erm... and the team wasn't in a position to help, to offer any advice about it 'cause I think folk were too caught up with, **well**, what I don't know... too caught up with surviving the team, as it was at the time, because it felt really mental erm, and I think just very caught up doing their own stuff anyway. Erm, I think it was just a really difficult time and I think it wasn't solely to blame, but I think that it contributed to my, just, not feeling I could do this anymore.*

P06 goes on to talk about the emotional impact of feeling unsupported in her work:

*P06: 424-439*

*I: I just was wondering about the phrase 'messes with your head' how you would, what you meant by that, how you would describe that?*

*006: Well I think it leaves you feeling like you can't do the job, you can't do the work, erm... you're kind of rubbish at it and I knew I wasn't. Erm...leaves you feeling very anxious, very de-skilled, very over-whelmed erm and I think quite angry with the, with the kind of...the kind of process or the system that just kind of leaves you to get on with it..and that doesn't have the kind of... support built in or the opportunity to allow you to get support that you need when you need it. I think there was a lot, it felt to me there was a kind of culture that you take it all on the chin. 'Cause these are difficult families, what else do you expect? That was never said but it felt like that. 'It's hard going [sighs] but just soak it up, soak it up, soak it up, do more and more and more, see more and more and more' [as if someone else's voice].*

In another section of the narrative, P06 also conveys a different experiential aspect of the perceived lack of support, here expressing a feeling of being at war, in the trenches. She has the sense of being surrounded by a culture of martyrdom, where

she feels there is an expectation of stoicism, indefatigability and self-sacrifice, of 'taking it on the chin':

*P06: 297-313:*

*I kind of soldiered on with him and the family 'cause I really didn't know what else to do and I didn't really feel that I could say 'I can't do this anymore and somebody has to take this case on'. I couldn't have said that.*

*I: You couldn't. What would have stopped you?*

*006: Erm.... I don't know, I don't know, I think I would have felt that I had failed, that I was weak and couldn't fight, you know couldn't do the work erm... it was, for me it just didn't feel like there was permission at that time to do that, to say that...*

*I: Permission from...*

*006: I guess the team, and the kind culture that was around at the time of just battering down the hatches and you know getting in your trench. It felt like a battle; you just dig in and fight the fight, and take it on the chin and kind of get on with it erm...*

Although P05's experience differs in that she did not become unwell as a result of a perceived lack of support, there is a similar reflection on a sense of isolation with an emotionally demanding case. P05 feels that therapeutic support would have been a useful accompaniment to working this case.

*P05: 490-497*

*I think that had I been given the opportunity to undergo some sort of therapy, and I'm not sure what that would be, I say therapy very loosely, that maybe I wouldn't have had to have gone through that, when working a case. And gone through that **alone**. Because while I had [colleague] there, it wasn't a therapeutic relationship that we had, it was very much a consultant type relationship. Although it did help.*

The difficulties of working in isolation are also echoed by P09, who indicates feelings of low mood associated with working as a solo practitioner.

## 5.7. Theme five

### ***Emotional learning and depletion***

This super ordinate theme encompasses participants' accounts of emotional learning and emotional depletion within their work. Aspects of each sub theme appear to fall under the heading of both learning and depletion. There is therefore a sense of overlap within these categories. It is for this reason that 'learning' and 'depletion' are combined as one rather than two themes.

#### ***5.7.1. Getting to know oneself***

Seven participants talked about gaining self-understanding through their work. This seemed to relate particularly to a feeling of increased understanding about one's own emotional life:

*P05:636-638*

*I maybe have more of an understanding about feelings, my own feelings and what that means.*

*P09:183-194*

*I hadn't realised how important the work was to me psychologically, to be helpful. And so I was in a position that I had all this free time, which was wonderful for the first time in my life, but I didn't have a big practice and I was living on my own too and I actually got quite low. Then I kind of cottoned on that all these years that I thought I was actually being helpful to other people I was actually helping myself at the same time [laughs] erm, so that was a kind of realisation I suppose of what the work does for you as opposed to what you do for it.*

For some this was accompanied by the recognition of personal emotional vulnerability and what one is able to cope with:

*P07: 230-232*

*I guess if I'm struggling with anything I do get tired [laughs], so that's the first barometer that things are affecting me when I get tired*

P06: 665-670

*I'm much more able to say 'no, I'm not seeing that family, not doing it. Don't mind doing it with somebody, but I'm not taking it all on.' So I think I've become much more aware of my limits. Erm... and much more able to say this is stressing me out.*

### **5.7.2. Compassion towards self**

Linked with an increased self-understanding, some participants seemed to have developed a more accepting, tolerant stance towards their perceived failings and faults, notably as a result of working with particular cases. This seems to reflect a move away from an expectation of perfection and a move towards a more balanced, realistic stance. For P06 and P07 this change comes in the form of 'allowing' themselves to have fun outside work, something which again illustrates a shift from a position of over-responsibility. For P08 and P05 however, self-compassion related particularly to their parenting of their own children:

P08: 756-763

*I was always quite good at beating myself up at how good I was as a mother and actually erm I've probably reached the stage where I think I'm an ok mum, I'm actually an ok mum. I do ok. I understand that children are much more resilient than you think they are (okay). So on a personal level it has definitely helped me to think about how I engage with and think about my children, you know, an awful lot more.*

P05: 342-249

*So yeah, really just thinking about it and sort of acknowledging that you know, you didn't do anything drastically wrong. And also just sort of acknowledging that in very many ways that family were struggling in just the same way that me and my [partner] must have struggled at the time you know. [4]. So just being able to sort of ease up on myself I suppose and not give myself such a hard time. And that maybe working that case helped me to do that.*

P04 uses Winnicott's (1986) concept of being a 'good enough' parent, acknowledging that she can be a 'good enough' therapist and does not have to succeed with every case:



P04: 596-600

*Sometimes it is just having to be, being able to, being able to fail and that's just I think the same sense that I have. Being good enough..a good enough parent... the, therapist being good enough as well [laughs].*

### **5.7.3. Mastery of emotions**

Six participants described a growth in their confidence as a practitioner. This seemed to relate particularly to a confidence in being able to master powerful emotions within therapy, either in oneself or in one's client:

P03: 644-663

*Sometimes I think those changes are confidence to survive some things. And by that I think I mean some of the hairiest cases I've had, scary angry people who make you experience anger at a level that you hardly know exists in yourself sometimes. Learning to survive some of those cases and actually do well with them and see them go out the door brings an enormous sense of satisfaction, confidence –in my ability as a professional and my ability as a person to have survived, coped and taken forward you know... [lines 654-656 suppressed]...we see some of the nastiest individuals sometimes that are called parents, that come through this department [laughs] and it evokes so many powerful, powerful feelings that you have to manage, that you have to control and you have to kind of put back in a way that's going to help a child's life improve. So I think a sense of achievement from that can be terrific.*

P05 describes this in a similar way in reference to a recent case:

P05: 572-582

*I would say it probably gave me a little more confidence and also confidence that you can be affected emotionally by things, and I think we are all often emotionally affected by things, and that actually you can keep a handle on your own emotions. ... [line 580 suppressed] but that particular case made me realise actually I can be professional even though I'm experiencing quite painful feelings.*

Similarly, P07 has discovered ways of coping with her client's distress and her own empathic reaction to this:

P07: 474-480

*So I learned to deal with her silences, I learned to deal with her distress because again, I'm not very good at seeing people cry. I always kind of want to cry too, so when she was in real distress and was crying I was able to kind of not sob! [laughs].*

P03 comments that her ability to master her emotions has made her more competent in her job, allowing her to ask difficult questions that need asking rather than avoiding them, as she might have done earlier in her career:

P03: 857-870

*Thinking back now, there was loads of examples of avoidance going on because I didn't want to ask that question, do you know, or I'm not happy about what that answers going to be. So for whatever reason I did avoid and I wouldn't do now, because I have a much better understanding in myself that that's the very thing that needs to be done now. It's not to have that anxiety or to act on that anxiety about doing something about it. But in the early days there wasn't the confidence or the knowledge or the skills there to do that, so I think there is something about being able to interpret what's going on. To allow yourself to know that you can do the straightforward things like ask a question, where my own emotions might have got in the way before.*

For another participant this sense of mastery was related to emotions within personal relationships:

P08: 782-789

*I think, you know, you can be angry about something else and take it home and be angry with the other person and I'm able to recognise that more and stop myself and say 'this is not about that, this is about such and such.' I have more of an insight into that and I'm able to go back and say 'that wasn't helpful' and wasn't really about you. I'm more able to do that and you can't ignore that awareness really. Once you have it.*

#### **5.7.4. Sense-making: knowledge, reflection and space**

The theme of emotional 'processing' and sense making was strongly represented in several accounts. Two participants gave very rich accounts of this theme, suggesting that their ability to 'process' their work relates to the way in which they cope the emotional impact of the work.

For P03 there were strong temporal comparisons, indicating a change in her clinical and emotional understanding from then to now:

*P03: 49-56*

*but I don't know if faced with the same problem now I'd experience it in the same way because I think my understanding has evolved. So I might experience it as something different erm ..*

*I: So kind of looking back, your take on it now is a bit different to how it..*

*003: [interrupts] I think my take on it now is very different and I..would see that being about understanding.*

P03 refers a number of times to the importance of 'processing' for her. She links her ability to 'process', to her ability to formulate cases in detail. She contrasts her seemingly simplistic sums as a novice worker to her more experienced 'mathematical equation', which seems to allow her to make sense of the emotional impact of her cases:

*P03: 164- 170*

*I think my lack of experience, my lack of knowledge, my lack of understanding didn't allow me to process things in the way I would do now.*

*I: [5] Okay, can you say any more about what you mean?*

*003: I think I couldn't put the pieces together well enough, and there was a kid that had been abused and to some extent that answered why there was a disturbed girl there and so there was abuse equals disturbance in my mentality, if you like, or my brain at the time.*

*P03: 179-180*

*But I couldn't put it into the equation the same way I would now.*

The analogy of using a mathematical equation, to 'process' the emotional aspects of the work is interesting, particularly given P03's contention that she isn't good at maths. This seems to suggest a need for gaining some order or control over the complexity presenting to her. P03 goes on to explain what she perceives to be the mathematical processing:

*P03: 781-803 [lines suppressed 786-794]*

*I: I think that's a really interesting idea about processing things differently. I wondered if you could say a bit more about what you mean by that?*

*003: For me there's something about making sense of what you hear, what you see, what you feel (um hmm)[lines suppressed]. It's how I make sense of what I see and hear and feel in the room, it's how I understand the problems as we see them and how I manage that [3] and what I learn from it to then take back to keep the system moving forward and in the right direction, so it's the maths. I'm crap at maths but I think emotionally there is something about things absolutely having to make sense to me or I can't do it.*

*I: What helps you to make sense?*

*003: I think it's what you're doing just now, do you know, it's picking, it's absolutely picking apart the details to make sure you understand what's being communicated..*

For P07 there was also a 'filtering out' through 'processing', a separation of her own emotions from those of her client. For P07 having 'mind space' is key for processing to take place. This is again an interesting term, conveying an image of her mind feeling crowded or pressured. The processing again seems to be a way of creating order:

*P07: 636-639*

*I: And when you talk about processing, what do you think that is for you?*

*007: I guess it's about filtering out what is the person's stuff, what's my stuff, what I can do about the person's stuff, what I can do about my stuff and sorting that out.*

*P07: 127-131*

*you need to have the space for that type of work and it was a really intense piece of work. I mean mind space rather than personal space and..it's sometimes difficult to be that intense and then come out of a session and go into a session with a kid.*

Similarly, P10 and P05 also talk about a need for 'space' and feel unable to secure this space during their busy working day. Their description of this again pertains to a need for 'thinking' space rather than environmental space.

For both P03 and P07 there was a sense of learning to process more effectively by themselves, requiring less support from the team to do so. P07 nevertheless illustrates how effortful this processing can be for her, suggesting it is far from an automatic process:

P03: 769-772

*I think supervision's really important and does help you to process things but maybe the experience means that I process an awful lot more myself than I need the team to help me process now but I would still need supervision.*

P07: 594-614 [lines suppressed 603-607]

*So I'm much healthier in this job I think, intrapsychically or whatever, I'm much healthier erm..and I think it's to do with the space to process. Sometimes it's not about processing it with another person, I don't, sometimes you do need to do that, but it's mostly about the space [lines suppressed. I can reflect back..and again it's just about the space, being able to have the space to think and to have the space to process. I keep using that word as if it's..but that's, it is about thinking, it's about working through things, it is about thinking, what's going on for me, then it is about finding out, about reading, about discussing it with someone and thinking oh, maybe that's what it is and finding out a wee bit more about it.*

### **5.7.5. New ways of working**

The majority of participants talked about a feeling of confidence in developing their own ways of working over time. There was a feeling of developmental progression, which seems to allow a greater creativity and courage within the therapeutic process:

P08: 394-406

*I would never have been able to do this case five years ago put it that way (um hmm). I really don't think I would have had the confidence to do this five years ago, so its that bit about my knowledge that the sharing of skills and knowledge of working with my colleagues, I feel as if I'm beginning to take ownership of my own growing, learning curve now. You know, you're always learning (yeah), I don't think you never ever finish that but I think I'm becoming aware of how far I've travelled.*

P08 goes on to talk about the importance of developing a psychodynamic understanding:

P08: 462-472

*I have...more insight and knowledge about the unconscious mind if you like or, an awareness of how behaviours can manifest, can represent an underlying problem if you like, they might manifest in a physical illness, where there's, you know, it's my knowledge that that can happen. I'm trying to think of a concrete example, because I remember when we used to have children who would soil and smear and you know have enuresis and I used to think 'God, isn't that awful, I wouldn't have a clue what to do with that!' (um hmm) I need help'.*



Similarly, P06 also now draws on a more diverse knowledge base for her work:

*P06: 780- 790*

*I think everything informs now, I think rather than just working in a particular way erm... I think it all informs, I don't mean it's a messy mish-mash, I think it all plays a part now so I wouldn't, I don't think I work in a particular way anymore. But I think I've got quite an eclectic way of thinking about difficulties now and if a child needs what I would call supportive counselling I could do that, but if they need much kind of structured kind of CBT way of working I could do that as well So I don't think anything's kind of ruled out or ruled in. And it feels much better actually.*

For some there was not only an increased eclecticism but also a new freedom to be creative in therapy:

*P08: 862-867*

*but it would be being able to use questions in a way, imaginative questions that I wouldn't have thought of before I guess. It's ways of engaging with families that I wouldn't have thought of before or wouldn't have even asked, thought to ask the questions*

*P09: 480-491 [lines suppressed 483-490]*

*I think I'm a bit more creative then I used to be [laughs]. I think I've got far more range of things that I do with people than I used to but I'm really happy with working individually, with doing family work [lines suppressed]... I just like doing what fits for the person and their situation.*

Confidence also extended to bringing cases to supervision to discuss. For P06 there seemed to be a confidence in being able to admit to uncertainty and to openly acknowledge her negative feelings towards a client. The idea of being able to 'explore' seems to be a key concept, again suggesting a greater freedom:

*P06: 785-786*

*when you're new and you are presenting a case you feel you're exposing your practice and exposing yourself, you know, the bits you don't know, you're unlearned. I'm not saying I know it all now but I'm much more used to presenting stuff and saying 'I haven't a clue why I brought this today but I want to just talk about it today, I want to explore...some anxiety that I have and want to bring it' or, I've just brought a case because maybe I've had a really strong reaction to one person and just hated a mum and not understood [line suppressed], and I take that to supervision to think 'what's that about?'. I need to take that to supervision to find out what that's about. Whereas before I would have just perhaps dealt with that or*

*thought 'what am I like?' or forced myself to like her in some way do you know? Now I would explore that in a different way.*

P09 also described discovery of a new, more light-hearted approach to her practice. Interestingly she seemed unafraid to use her personal experience for therapeutic effect:

*P09: 641-645*

*I think I've got more light-hearted and laugh with people more and I like that and think that's good for people and erm..I'm a bit..more...erm..take more risks, more playful... [6].*

*P09: 713-718*

*I don't think I probably would have done that way back. It's partly taking a personal experience but its also knowing where you're going with it and knowing and actually being quite light hearted about the whole thing and laughing about it and a wee story and a personal experience*

For two participants there was also something beyond creativity, a sense of a more spiritual aspect to the therapeutic encounter:

*P09: 750-775*

*When we've had a creative moment I feel great. Sometimes, I love writing poems, not that it's anything to do with work but it's a bit like 'oh, where did that come from?' and sometimes it's a bit like that with therapy it's like 'oh!' [excited tone]. Somehow between you and the people or child or family or whoever it is, something really creative has happened and you think 'yeah!' [laughs].*

*I: It's a good feeling is it?*

*009: It's a great feeling. I like the fact that it somehow comes from somewhere else, it's something about you being together that makes this thing happen, it's like 'oh [high pitched], a daisy's grown, great!' [gesturing to the space between us].*

*I: What does it mean to you being able to have that experience?*

*009: I think it's quite a spiritual thing for me, it's kind of like erm [13]. It just puts me in awe really [smiles].*

*I: In awe of?*

*009: In awe of life [smiles] or something [laughs].*

*I: Um hmm [8]*

*009: It doesn't happen all the time; I'm not in awe all the time [laughs], but occasionally [laughter].*

*P10: 602-624/[lines suppressed 614-616]*

*P10: I think there's a balance between, you need boundaries but at times when I've been working with people I've felt myself going to a deeper level. Do you know what I mean... do you ever have that experience, at times you feel you're going to a deeper level?*

*I: How would you kind of explain that more? Understand that?*

*P10: Maybe it's about kind of joining with people. And ... Not rushing it but just letting it sink and connecting with them. And I think that's when people experience it as being quite therapeutic.*

*I: What's that experience like for you as a worker?*

*P10: I think erm... when you do it right it's quite a satisfying thing. So I think I do get a lot of satisfaction out my work.*

### **5.7.6. Self protection**

Most participants talked about a need to nurture and look after themselves both in and out of work. The key uniting aspect of this experience appeared to relate to drawing tighter protective boundaries. This is played out in several ways across accounts. For many, this related to a need to gain 'balance' through fun, humour and laughter. There was a sense however of this being an effortful process, a self-protective strategy, which seems to stem from a recognition of the potential toll of the work:

*P10: 695-700*

*I think one of the ways I cope in life is through a sense of humour. I think I'm jokey, erm... I try and have a bit of a laugh, I don't mind being a wee bit ridiculous, a bit off the wall at times. And I think at times if you didnae laugh, you'd greet.*

*P07: 742-745*

*I need to have a bit more fun and that it's okay to do that. Its not that kind of work ethic that I can actually have fun and its actually valuable, it balances out you life.*

*P04: 765-773*

*I think you see enough crap in the work that you do. So when I'm out of work I like things as stressful [corrects self] as stress free as possible erm, that's why Disney's and comedies have been invented [laughs]. You think enough at work and you don't have to think outside of work and I don't, I mean, I don't want to know too much about the horrors of the world when I'm out of work either, because work can be horrible enough.*

P09 gives an impression of needing to protect herself by limiting her 'helpful' giving, which she achieves by spending time alone rather than in company:

*P09: 369-390 [lines 371-383 suppressed]*

*I never want, sometimes when I go on holiday I never want to see another person [laughs] and I can't bear parties and that sort of thing, ... [lines suppressed] ... there's just so much, so **much** of being around people that I kind of want to..and the other thing is I have this really strong sense of wanting to be helpful to people, which actually makes it quite difficult then I think to relax. Like, because you know if I have a dinner party then I've got to look after everybody and so I don't hold parties because I would have to look after everybody*

Other participants talked about a need to look after or protect themselves at work, for example, P10's need to 'avoid' conflict, a term that would suggest this being a defensive manoeuvre:

*P10: 810-816*

*I wonder if sometimes with lesser situations if it's easy for me to make excuses for people rather than get angry with them and find a way of challenging them. I wonder if... I think maybe, although people here might not, might find this hard to believe, erm, I wonder if I avoid conflict far too much. Erm.*

Another participant talked about developing a new 'cynicism' at work. There was a sense of this cynicism being necessary to protect her from needing to give too much to clients at a time when she reports feeling tired and drained:

*P05: 728-734*

*But I think I'm the eternal optimist but I think more and more the cynicism is creeping in and maybe that's what I need, maybe I need a bit of realism, you know. And actually I've been thinking recently that maybe I need to not be so erm... needing to feel that I have to give the absolute best to every single case you know. Erm and I think as [previous job] I got very worn out because I treated every case the same.*

For P06, there is a need for her to draw boundaries, to limit what she is prepared to do independently. Again this appears to serve a protective function:

*P06: 706-717*

*There's been a few cases that I think are quite kind of stressful and erm... okay its my case I'm the case manager but I've said 'I'm not going to this child protection*

*review on my own, somebody needs to come with me, and I need you to see this boy, 'cause I think he's got ADHD and I think he's on the spectrum and you need to see him.' Fine. And I'll see him with you, but you need to see him. Erm 'I'm not seeing this woman on my own. Cause she'd get you hung [laughs]. Somebody needs to see her with me.' I think the kind of difficult families that we see, I want a hand with them because I'm not doing it myself.*

### **5.7.7. Strain and ill health**

Two participants in particular (P05 and P10) highlighted aspects of strain within their current roles. Both reflected feeling 'worn out'. It is interesting that P05 here talks about not having 'space' to do things at the weekends, a word which calls to mind P07's ideas about processing and the need for 'mind space':

*P05: 693-697*

*I feel worn out. Many weekends I feel completely washed out, worn out. Emotionally drained sometimes and I think that impacts on your life. It impacts on your personal life. You don't have the space to be able to go, you know, do things that you used to do.*

*P10: 628-630*

*I get more and more frustrated with it and I think: 'have I got the energy to keep doing this for very much longer?'*

The same participant also described a change in emotional reactivity:

*P10: 729-731*

*So things like that, you just go off on one. Totally out of proportion, to the situation.*

*P10: 673-672*

*I've actually got quite.. funny... because I used to be a pretty tolerant, easy going person who always tried to be nice to people. And I think I've lost that now and I can be really bloody grumpy and very difficult*

Two other participants talked about historical experiences of becoming unwell at work and consequently taking long periods of sickness absence. Both participants commented however that although difficult, these illness experiences had led to a feeling of greater health and insight. There was therefore an impression of gain for



these participants, which can be contrasted to P05 and P10's accounts of currently being within a difficult experience:

*P07: 584-596*

*I kind of processed I guess, or I worked through what was making me unhappy and worked out how unhealthy that was actually to throw myself into work and not kind of deal with stuff. I suppose I kind of dealt with things that were going on in my own life, erm...and I learnt that yeah, you know what, you can learn from these experiences and I think I had the insight to know it has to stop now before it gets any worse if you like. So I'm much more healthier in this job I think, intrapsychically or whatever, I'm much healthier erm..*

*P07: 626-630*

*I think the experience of feeling that you can't manage or you can't cope... it's been a very useful experience. Looking back. I mean it was bloody hellish at the time*

## 6. Reflective account

Within interpretative qualitative research of this nature, the importance of 'reflexivity' (Yardley, 2000) and 'owning one's own perspective' (Elliott *et al.*, 1999) are emphasised. In recognition of this, I kept a diary of my experiences and reflections throughout the research process. I have used this diary to illustrate below my experience of the research process. It is intended that this will shed light on both my own influence on the research and also the influence of the research on me, in my dual role as both researcher and clinician.

### Recruitment

In order to recruit participants to take part in this study, I attended departmental team meetings to outline the research to potential participants. I was struck by the varying responses to my invitation to take part, which ranged from zealous enthusiasm, to indifference, to thinly veiled irritation. I began to think about what might have motivated my eventual participants to volunteer, particularly since they seemed to do so with little hesitation. I wondered if there might be something that set these participants apart from other members of the department. Perhaps they were particularly reflective people, perhaps they were particularly at ease with discussing their own feelings, perhaps they had a particular story to tell, or perhaps their enthusiasm reflected a need to share an experience or a need to be heard? Whatever their motivation, I was aware that this was a self-selected sample of participants and that this would influence my research in particular ways.

### Interview Process

I felt nervous about the interview process for a number of reasons. I was aware of the need to step away from my habitual 'therapeutic' mode of interviewing and to take the more conversational and open stance needed to elicit the rich and nuanced experiential accounts necessary for IPA. Secondly, I knew my participants to varying degrees, having worked closely with some over the past 18 months while

only having a passing acquaintance with others. I was anxious about how my position as colleague and trainee might impact on the interview process, particularly whether this might have an inhibiting effect on participants' responses.

With increasing experience of the interview process, these concerns became less pressing. Indeed, I was surprised by how open and honest my participants were and by how candidly they spoke of some very personal experiences. I felt quite humbled by the trust they placed in me in sharing these accounts and was concerned that the interview process should not make them feel exposed. I was aware that the interviews sometimes touched on some very personal and emotional content and that as interviewer I sometimes tried to 'manage' or 'pace' the emotional output by asking a fairly neutral or 'grounding' questions at points where I perceived there to be high emotional content. I wondered if this was my need to 'protect' my participants, to try to give them an emotional 'exit', or to protect myself in some way.

I came to recognise that my familiarity with the participants meant that they seemed to relate to me as 'one of them', giving knowing smiles and laughter at certain points and also perhaps looking for affirmation or validation at times with appeals of 'you know' or 'doesn't it'? My neutral stance as researcher meant I was unable to reply to such appeals, something that felt at times uncomfortable for me. I was also aware, however, that my 'insider' status might also give me quite privileged access to experiences that might otherwise be less readily voiced.

Similarly, I noted that many of my participants asked me at the end of the interviews whether other participants had responded similarly. Although my duty of confidentiality meant that I was only able to reply in very brief and general terms, it was interesting that they seemed curious to know if they were the 'same' or 'different' to others. I guessed that this might be due to an anxiety about some of the content of the interviews, perhaps they were wondering whether they had been 'unprofessional' in some way, or whether there was something different or unusual

about their experience. I also wondered if their curiosity might highlight a lack of professional sharing of these kinds of experiences.

### **Analysis**

During the analysis phase I became aware of feeling quite a sense of responsibility towards my participants, a need to do justice to people's accounts and to try to understand and reflect as accurately as I could the essential meaning of their experiences. I also felt very time-pressured and this raised my anxiety about this issue. I was keen for example to gain participant feedback on my themes but was unable to do so within the available timeframe.

As the themes began to come together I reflected on the similarity between my sense of responsibility to my participants and their sense of responsibility to their clients. I wondered why there seemed to be this parallel and whether it was something to do with the strong emotional content of the interviews, which in turn echoed the emotional content of the participants' work with clients. I mused over whether this 'emotional' aspect had become something of a 'pass the parcel', with a contagious connection from client, to therapist, to researcher?

### **Final stages**

As I became more and more immersed in the intensive process of data analysis, I began, at times, to feel quite shocked and weighed down by aspects of the accounts. Like P03 who had a 'preconceived' idea what an abused child might present like, only to be awakened to reality, I realised that I perhaps also had a preconceived idea that there would have been a greater weight of positivity within my accounts. I became aware of the powerful language used within the accounts, words like 'hellish', 'harrowing', 'painful' and wondered if this in itself could be a symptom of vicarious traumatisation – perhaps my participants were well versed in the language of trauma and were unaccustomed to thinking (or talking) in more positive, growth-related terms.

## 7. Methodological Critique

IPA was chosen as the most appropriate methodology for the purposes of this study, as outlined in section 4.1. There are however, a number of limitations to the approach, one of which seems particularly pertinent to this study.

Willig (2001) outlines that IPA '*relies upon the representational validity of language*' (p. 63) in order to understand experience. That is, it assumes that the language used to describe an experience represents the 'true' experience, rather than acknowledging that language has a role in shaping the experience itself. Although the use of language was to some extent interpreted within this study, a greater appreciation of its role in these accounts would perhaps add further depth to the study. For example, the manner in which the participants talk about their experiences (for instance the intensity and occurrence of postulated 'trauma' related language) would be an interesting avenue for further consideration.

Although the sample for this study was not intended to be representative of CAMHS clinicians in general, there are certain qualities of the sample that require comment. The fact that the sample was entirely female, although indicative of a strong female bias within the workforce, means that the experiences of male clinicians within this service, which may differ from those of females, can not be said to be represented within these findings. Similarly, it should be noted that the findings of this study represent the experiences of therapists working in a CAMH service, rather than experiences of working with children or young people *per se*. The fact that three clinicians chose to speak predominantly about experiences of working with parents rather than children precludes specific conclusions about the experience of working with children and young people.

Qualitative research (and IPA in particular) '*acknowledges the existence of multiple views of equal validity*' (Barbour, 2001, p. 1117) and it is therefore recognised that there may be a number of possible alternative interpretations of the data. In



recognition of this, the position of the researcher has however been acknowledged throughout this study. The researcher reflected on the possible bias inherent within this position and aspired to achieve openness towards variant interpretations of the data. Additionally, the credibility of the themes was independently corroborated by supervisors, with particular regard to the perceived fit between themes and the original data.

Credibility checks in the form of respondent validation were not sought for this study. Although this was largely due to the time limitations of this study, Barbour (2001) has also questioned the utility of such checks, highlighting that such checks can be labour intensive and can sway data in the direction of participants individual concerns or agendas.

## **8. Discussion**

### **Comment on theme one: emotional exchange**

Theme one captures the emotional impact within these therapeutic encounters. Emotions seem to be both put into and drawn out of the participants in multiple ways. The emotional impact is also seen to be carried through to the present.

It is striking that the impact of these therapeutic encounters is described as being held not only in the mind in the form of images and thoughts but also within the body, where it is 'under the skin' and within the 'system'. Participants report feeling 'worn out' and 'washed out' by these emotional experiences, suggesting a systemic as well as a cognitive impact.

There is an increasing recognition in the literature that stress and psychological 'trauma' have a significant influence on the body as well as the mind (e.g. Rothschild, 2006), something that may be reflected within these descriptions. Indeed, Pearlman and Saakvitne (1995) highlight the impact of 'body-centered

countertransference', where the client elicits somatic symptoms in the therapist which parallel their body experience, as could perhaps be manifest in P07 and P04's accounts of hunger in working with underweight clients.

It sub theme 5.3.1, '**putting things into the therapist**', it is notable that there are descriptions of intrusive imagery and metaphors of invasion, particularly (but not exclusively) in relation to working with abuse cases. These descriptions would seem to concur with existing descriptions of vicarious traumatisation, where the '*intrusion of violent imagery into the therapists' inner life*' is said to be a 'hallmark' symptom (Pearlman & Saakvitne, 1995 p.285). Both P07 and P03, in describing working with sexual abuse cases, use language that is particularly evocative of the abuse experience, with P03 talking of being 'penetrated' by thoughts of the child and P07 having 'bad stuff' put into her. The continuing emotional impact of these experiences within the research interview, the hypothesised 'reliving' experience, would again recall a manifestation of vicarious traumatisation, which Pearlman and Saakvitne (1995) indicate can 'cloud' cognitive processing. It would also seem to indicate an ongoing (conscious or unconscious) need to avoid these feelings.

References to 'soaking up' the client's emotions and taking on aspects of the client's experience evoke psychoanalytic concepts of transference/countertransference, projective identification and containment. What is of interest however, is the way in which these accounts convey the potency of this sense of 'doing to' the therapist, highlighting the extent to which these therapists seem to feel emotionally and physically 'used' and depleted within these therapeutic encounters. Participants seem to have difficulty in disentangling their own emotions from those of the client and describe experiencing painful emotions on behalf of the client.

The therapeutic relationship, and particularly the process of containment, has been likened to the parent-infant relationship, (Lanyado & Horne, 1999) where the parent must be able to accept, think about and 'digest' the infant's projected emotions in order to facilitate the infant's emotional growth. Again, while the experiences

described by some participants fit well with the established psychoanalytic concept of containment (Lanyado & Horne, 1999), it is striking how strongly represented these experiences are. In contrast to a healthy parent–infant relationship, these therapists convey a sense of being left holding the emotions, left with the dilemma of what to do with them.

Sub theme 5.3.3: **‘exposure’**, which is conveyed particularly vividly in relation to working with abuse cases, again evokes concepts of trauma and vicarious traumatisation. Participants describe the experience of being confronted with a brutal reality, of the ‘other worldly’ becoming ‘this worldly’. These descriptions, together with the perception of a ‘baseline’ shift (P07) are highly resonant with the idea of schema change within vicarious traumatisation. It is of particular note that despite working with an adult survivor, P07 describes seeing ‘a child of 3 being abused’, something that would concur with Brady and Guy’s (1999) hypothesis that adult sexual abuse work exposes therapists to similar trauma to working with abused children.

### **Comment on theme two: the personal and the professional**

The central tenet of theme two is the experience of a struggle to manage the interface between the personally/emotionally involved self and the professionally/rationally involved therapist. This appears to lead to a tension and questioning for all the therapists involved in this study.

Pearlman and Saakvitne (1995) note that within countertransference reactions, familiar boundaries of the therapeutic relationship can become altered. According to this conceptualisation, the emotional impact of the client on the therapist appears to challenge therapist’s ‘ego ideals’ such as self as ‘healer’, causing ‘narcissistic wounds’ to the therapist, wounds which may cause the therapist to be inclined to extend or alter boundaries in order to ‘repair’ the injured sense of self. Of particular interest however are Pearlman and Saakvitne’s (1995) comments regarding ‘parental countertransference’, which they refer to as feelings of ‘protectiveness, fear, anxiety,

grief, powerlessness and love' (p. 82), a desire to act '*in loco parentis*'. Although this type of countertransference is referred to in the context of working with adult survivors of childhood abuse, it appears to resonate with the accounts of therapists within this study. A sense of maternal protectiveness and desire to nurture is conveyed within several accounts. This is illustrated particularly strongly within P03's account, where the neediness of the child challenges professional boundaries, seeming to call to the humanity of the 'parent' within.

It is interesting that alteration to the personal/professional boundary seems to be represented so strongly within these accounts, particularly given that not all of the participants relate experiences of working with abuse or typical 'trauma' cases. One might wonder therefore whether this particular type of 'parental countertransference' experience might be especially pertinent to CAMHS work in general.

The apparent tension or anxiety around the personal/professional role was an unexpected finding, which raises some questions about how participants might conceptualise the distinction between the personal and the professional. This particular theme does not appear to have received extensive attention within the empirical literature. Where boundary issues are discussed in the literature (e.g. Barnett *et al.*, 2007) and professional guidelines (e.g. BPS Code of Ethics and Conduct, 2006), the focus is on 'boundary violations' such as sexual misconduct or dual relationships rather than the more subtle tensions reflected within these accounts.

The tension between professional role and personal feelings is pervasive within this sample and indeed, seems in large part to account for why these particular cases stand out for participants. The questioning of how appropriate it is to feel strong emotions towards and in the presence of clients and an apparent discomfort with this is conveyed both explicitly and also implicitly within paraverbal features of these accounts.

This finding raises some interesting questions about cultural or normative views of therapy (or therapists), which seem somehow to conflict or be dissonant with these participants lived emotional experiences of therapy. There is a sense within these accounts of therapists aspiring towards (or having aspired towards in the past) almost mythical ideals of therapist as rational, infallible, in control, free of emotional struggle, and perfectly boundaried. These ideals are perhaps a manifestation of having a social identity of self as a professional/ therapist. Servais and Saunders (2007), have identified the operation of ‘disidentification’ in psychologists, a process characterised by perceiving those with mental illness as being different from ‘normal’, whilst maintaining a view of oneself as ‘normal’ and therefore not vulnerable to mental illness. This process of ‘disidentifying’ has been seen to be self-enhancing (Servais and Saunders, 2007) and may allow a psychological distancing from perceived ‘client’ characteristics such as emotional vulnerability. The therapeutic encounters described in this study however, would appear to challenge the therapist/client dichotomy, bringing the therapist’s own emotional vulnerability into sharp focus.

Interestingly however, there also appears to be an organisational contribution towards the upholding of these ideals. Many participants indicate a perceived lack of organisational recognition of the emotional impact of the work, with one participant in particular (P06) perceiving a culture of ‘martyrdom’ and an expectation of ‘being brave’ and ‘soldiering on’. This would suggest that there might be both individual and wider organisational contributions towards the upholding of such ideals.

### **Comment on theme three: responsibility**

Theme three describes the participants’ feelings of responsibility for these clients. The cases described by participants appear to provoke feelings of anxiety and self-doubt, even within experienced therapists. There is an impression of the therapist feeling like a lifeline, the ‘axis’ (P08) for the client and of feeling burdened by this perceived responsibility.



The concept of responsibility does not appear to have received particular attention within the literature regarding the impact of therapeutic work. It is of note that this theme was particularly strongly represented across accounts (with the exception of P09) and formed a major component of the narratives.

The theme of '**holding on**' (section 5.5.1) is a salient sub theme of responsibility. Winnicott's (1986) conceptualisation of the 'holding' of therapeutic emotional containment would appear to have some overlap with the sense of 'holding' conveyed within this study, however, there are also perhaps some important differences. The life/death feel to the therapists' 'holding on' conveyed within these accounts has for some a desperate and urgent feel, a 'scariness' (P08) which appears to differ qualitatively from the idea of therapeutic 'holding'. It is as if the participants customary parameters of responsibility are stretched, both beyond the realms of reasonable professional responsibility and reasonable personal responsibility. The sense of being a metaphorical 'lifeline' to the client conveys the extent of the feeling of personal responsibility experienced within these therapeutic encounters.

The need to arrive at an appropriate level of responsibility appears to be a developmental task requiring negotiation. Many participants evidence a struggle to reconcile professional parameters of responsibility with the emotional reality of these cases. The personal consequences of the responsibility for 'holding on' are recognised by two participants, who have come to realise the important protective function of being able to 'let go' appropriately. This nevertheless appears to be a difficult task to achieve, particularly when the client is seen to have a high level of need.

The concept of 'parental countertransference' could perhaps provide a useful framework for understanding the experience of responsibility evidenced within these accounts. It is possible that that these clinicians are experiencing a particular form of countertransference, which may be particularly prevalent within work of this nature. The concept of there being particular dynamic processes at work within CAMHS work is however, under-researched (Krimendahl, 1994).

### **Comment on theme four: support**

Theme four encapsulates participants' accounts of the importance of support in their work and the impact of a perceived lack of support.

Participants described the role of the team in providing emotional support in various ways. Team members seemed to have a role in helping participants to understand, cope with and gain perspective on their emotional reactions to cases. The idea of the team fulfilling support needs that 'lay' friends cannot meet is supported within the literature, which suggests that the 'stigma' of working with trauma and abuse can leave professionals isolated and unable to seek support from friends and family (e.g. Azar, 2000). Azar (2000) suggests, for example, that mandates of confidentiality as well as a fear of 'contaminating' others with details of trauma can prevent therapists from sharing their emotional reactions with others. One participant however, (P05) presented an alternative view, suggesting that for her, family provides the greatest source of emotional support. P05 contrasted the family support to work, where there was a feeling of not being 'allowed', or not having time to feel the impact of cases. This again links to the idea of cultural or organisational expectancies, which seem to lack due regard for the emotional impact of the work.

The team at times also seems to fulfil a parenting function, seemingly helping to contain distressing feelings. The negative impact of lack of support and in particular a lack of cohesion within a team is very clearly conveyed by one particular account (P06), which indicates the potential for team dynamics to cause considerable distress. The occurrence of splitting within one particular team appears to relate well to descriptions of 'organisational pathology' previously mentioned in this study (section 2.2.1; Moylan, 1994), indicating the tangible way in which team dynamics can contribute to ill health.

### **Comment on theme five: emotional learning and depletion**

Within this super ordinate theme there is a suggestion of emotional growth over time, notably in relation to understanding and mastery of powerful emotions. For some this appeared to lead to a greater sense of competence and resilience both in work and in personal relationships.

Two participants described development in their ability to ‘process’ emotions. This conveys the importance of generating some order out of the complexity of emotions that arise in therapy through a process of careful ‘filtering out’ (P07) or a ‘mathematical equation’ (P03). The increasing ability to do this independently brings to mind Casement’s (1985) description of developing an enhanced capacity for ‘internal supervision’, which can provide immediate insight into the therapeutic process. It may also suggest a mechanism behind reported findings of greater vulnerability in less experienced professionals (e.g. Kramen-Kahn, 1998; Neuman & Gamble, 1995).

Participants described a progression towards more flexible and creative ways of working. This apparent developmental progression seems to have allowed these therapists to modify or discard some of the assumptions or expectations implied within a social identity of self as ‘therapist’ (for example, a view of self as ‘expert’), something which perhaps allows a greater acknowledgement of vulnerability and uncertainty within the work. For some it had taken a period of ill health to be able to challenge such expectations.

Participant 09’s account, which differed considerably from other accounts, is worth discussing at this point. This account conveyed the participant’s enthusiasm and passion for her work. This seemed to resonate with Dlugos and Friedlander’s (2001) report of the characteristics of ‘passionately committed’ therapists, particularly in areas of adaptiveness, transcendence and intentional learning. This participant appeared to be particularly growth oriented, seeming to transform the potentially negative impact of the work into an opportunity to learn and develop her practice. It

is possible that this might serve a protective function when working with difficult cases, indeed, Duglos and Friedlander (2001) have suggested that 'passionately committed' individuals are able to find a '*continually renewed energy source for their work*' (p. 303).

The ability to find '*continually renewed energy*' (ibid) can however be contrasted to accounts of ongoing pressure and strain perceived by some participants, descriptions of which are in keeping with facets of burnout (Farber & Heifetz, 1981). Some participants appear to feel burdened by difficult cases, and an apparent lack of organisational recognition of the cumulative impact of the work.

## 9. Summary

This study set out to investigate in depth the experiences of therapeutic work in a CAMHS setting. The aim was to gain a greater understanding of the perceived influence of the work and to explore the notion of change and development as a result of the work.

Five super-ordinate themes captured the essential components of participants' narratives: *Emotional Exchange*, *The Person and the Professional*, *Responsibility*, *Support and Emotional Learning and Depletion*.

Psychoanalytic concepts of counter-transference, projective identification and containment appeared to provide a useful framework for understanding participants' descriptions of the emotional exchange and impact of working with particular cases. Of particular interest however was the intensity of the emotion evoked within these encounters as well as the challenges these clinicians faced in managing these emotions. Experiences in keeping with symptoms of vicarious traumatisation were found within some accounts.

Elements of the 'emotional exchange' within therapeutic work (see section 5.3) were seen to challenge the understanding and management of the interface between the personal and professional self. The work was seen to elicit strong emotions, which appeared to be difficult to reconcile with the existing professional sense of self.

Participants described a burden of responsibility, something that was again seen to relate to the impact of the 'emotional exchange' in these cases. The feeling of responsibility was associated with changes to the participants' professional boundaries, again leading to tension and questioning. Negotiating or establishing an acceptable level of responsibility appeared to be an ongoing developmental task.

Team support was seen to be vital in enabling participants to cope with the emotional impact of their work. For some this appeared to relate to containment of feelings of anxiety in positions of therapeutic uncertainty, while for others attention was drawn to the role of the team in helping to 'process' difficult emotions. For two participants there was a perceived progression in their ability to process emotions independently, while for some other participants the negative impact of a perceived lack of team support and cohesion on participants' well being was conveyed. The perceived developmental progression in emotional 'processing' may relate to previous reports in the trauma literature (e.g. Kramen-Kahn & Hansen, 1998) of experienced therapists 'habituating' to the stresses of the work over time. This finding has importance as it suggests the potential for therapists to develop constructive ways to deal with the emotional impact of their work, in contrast to the development of more defensive or avoidant coping processes alluded to elsewhere (e.g. Affleck, 2005). Previous suggestions of greater emotional vulnerability in less experienced professionals (e.g. Pearlman & MacIan, 1995) may again tie-in with the idea of developmental progression in therapists' abilities to process complex emotions, suggesting a possible role for an explicit focus on supporting newer therapists' understanding of dynamic emotional processes at work.



Finally, there was a suggestion of growth in self-understanding, self-exploration, and emotional mastery over time, which was perceived to benefit both therapeutic and personal relationships. The reported move towards greater flexibility and creativity in therapeutic work was associated with an increase in feelings of competence and confidence and, for some, an experience of a more spiritual nature. For some participants however, descriptions of ongoing pressure at work highlighted less desirable emotional and attitudinal changes, which would be in keeping with symptoms of burnout.

### ***9.1. What can we learn from this? Implications for practice***

Interpretative phenomenological analysis was seen to be particularly appropriate for this study, enabling detailed exploration of the complexity and contradiction within these experiences of therapeutic work.

This study highlighted the significance of the emotional impact of the work to participants and indicated, for some participants, the presence of symptoms that are in keeping with vicarious traumatisation and burnout. It is well established within the literature that therapeutic work can have an emotional impact. The present study contributes specifically, by providing rich descriptions of the nature of this impact on the individual and its relation to experiences of self and responsibility within therapeutic work.

It is postulated that the concept of 'parental counter-transference' (Pearlman & Saakvitne, 1995) may provide a useful framework for understanding the experiences of these clinicians. The commonality within these experiences would suggest a need for greater attention to and acknowledgement of the emotional impact of the work at a professional level.

The apparent tensions in managing the interface between the personal/emotional and professional/rational were an unexpected finding, which suggests that further attention to this particular professional issue would be warranted. It is possible that there may be a perceived stigma or anxiety around discussion of these issues, perhaps relating in part to a conception of counter-transference reactions as being a result of the therapist's own 'unresolved' conflicts, rather than in its broader sense as '*the total emotional reaction of the therapist to the patient*' (Lanyado, 2004, p.41). Similarly, commonly used terms such as 'over-identification' and 'over-involvement' have an inherently critical feel, which may again preclude wider discussion of reactions that challenge the management of the personal/professional interface.

The finding that all of these participants have been challenged by these reactions would suggest a need for normalisation of emotional responses to therapeutic work, together with a greater emphasis on the importance of recognising, discussing and understanding emotional reactions to the work at individual, team and organisational levels. The literature indicates that despite positive societal shifts in attitudes towards mental health, many therapists continue to exhibit a '*fear of being a client*' (Walsh & Cormack, 1994). This fear may prevent therapists from acknowledging '*the existence of personal support needs*' (*ibid*, p.106). Walsh and Cormack (1994) also suggest that organisations such as the NHS have a large part to play in preventing acknowledgement of support needs, tending to emphasise productivity and output as indicators of professional worth.

Participants in this study evidenced aspects of emotional growth over time, something that was perceived to benefit at both a personal and professional level. For some participants a growth in the ability to 'process' emotions led to a feeling of greater competence and confidence at work. This was described as a constructive, active process, which requires cognitive space in order to occur. Interestingly, these descriptions correspond with Calhoun and Tedeschi's (2006) contention that 'constructive rumination' is necessary for posttraumatic growth to occur. Similarly, Cheng *et al.* (2006) indicate that pain must be experienced and constructively worked

through in order for development to take place. The hypothesised existence of barriers to expressing personal support needs combined with a prioritisation of productivity, may however work together to prevent growth from occurring.

The presence of some symptoms consistent with vicarious traumatisation and burnout within the present study would suggest a need for greater organisational support to mitigate these effects. Pearlman and Saakvitne (1995) have emphasised the inevitability of these reactions to trauma work but also indicate that symptoms can be mitigated with appropriate provision of support, such as supervision centred specifically on understanding and managing such reactions. This may be particularly important for less experienced staff (Neuman & Gamble, 1995).

Many researchers have emphasised that therapist care is an 'ethical imperative' (e.g. Barnett *et al.*, 2007). The present study suggests a need for greater attention to emotional reactions to the work, which have been shown to be complex and multi-layered. A greater emphasis on normalisation of these reactions, together with a focus on enhancing opportunities for emotional growth would be important steps towards meeting this imperative. This however, is likely to require the provision of adequate space and support to process the emotional complexities inherent within this work.

This study suggests that by recognising and acting to remove potential barriers to emotional processing and development, mental health providers can set up an exemplary model of mental health not as absence of symptom but rather as the presence of well-being, positivity and personal growth.

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# Appendix

## 1

## **Participant Information Sheet**

(24/09/07, version 2.0)

### **Study Title: Clinicians' responses to therapeutic work – A qualitative analysis**

My name is Jessica Hendry and I am a Trainee Clinical Psychologist, based in the [removed]. I would like to invite you to take part in a research study, which is being completed as part of my Doctorate in Clinical Psychology. Before you decide whether to take part you need to understand why the research is being done and what it would involve for you.

This information sheet is designed to tell you about the purpose of the study and what will happen if you take part. Please take time to read the following information carefully. Talk to others about the study if you wish. Please ask if there is anything you are unclear about or if you would like more information.

### **What is the purpose of the study?**

The purpose of the study is to investigate clinicians' personal experiences of clinical work through a series of open-ended interviews with individual clinicians. Individuals would be invited to reflect on clinical experiences that stand out in their minds and to discuss how these experiences might have impacted on them both personally and professionally. The study is open to all qualified clinicians working in [name], regardless of training orientation.

It is hoped that the study will enhance understanding of how clinical work affects individuals and how the potential negative impact of the work may be lessened. It is also hoped that the study may provide information about how staff can be supported to carry out their work and develop professionally.

### **Why have I been invited to take part?**

You have been invited to take part in the study because you work in [name].

### **Do I have to take part?**

Taking part in the research is entirely voluntary. If you do not wish to take part your decision will not be disadvantageous to you in any way.

You can take time to think over whether you want to take part. If you agree to take part in this research you will be asked to sign a consent form to show you have agreed to take part. You are free to withdraw your consent at any stage of the study, without giving a reason.

### **What will be my role if I take part?**

You will be asked to take part in an individual interview with the researcher, Jessica Hendry. Jessica will ask you a series of open-ended questions about your own experiences and feelings as a therapist. The interview is expected to last no longer than 90 minutes and will take place in the [name]. There will be no right and wrong answers; the researcher is interested in hearing your own views and experiences.

The interview will be audio-recorded onto mini-disc. The interview will then be transcribed word for word by the researcher onto a word processor. An anonymous participant identification number will be given to the transcribed interview. Only the researcher will know your identity.

**What are the possible disadvantages of taking part?**

It is not expected that there will be any disadvantages to taking part in the research.

**What are the possible benefits of taking part?**

Taking part in the study will not necessarily benefit you directly, although it is anticipated that it may provide participants with an opportunity to reflect on their clinical practice. It is hoped that the research will provide greater understanding of how professionals in the field cope with their work. It is hoped that this information may help to suggest ways in which clinicians can be appropriately supported to carry out their work.

**Will my taking part in the study be confidential?**

Yes. All information will be handled in confidence.

**How will confidentiality be ensured?**

Individual interview data will be recorded onto mini-disc. Only the researcher will have access to the disc and it will be stored securely in a locked filing cabinet.

Transcribed interview data will be given an anonymous participant code. Anonymised transcripts will be kept on password protected word processing computer files. Paper copies will be stored securely in a locked filing cabinet.

Due to the method of data analysis, other researchers including research supervisors may need to have access to anonymised transcripts in order to comment on the themes generated by the researcher.

The audio-recording of the interview will be magnetically erased following the completion of the doctoral thesis and transcripts will be shredded five years after this.

**What will happen to the results of the research study?**

Each individual interview will be qualitatively analysed in order to identify themes within the data. The results will be written up as a doctoral thesis and will be submitted to Edinburgh University for examination. Individuals may be quoted verbatim within the doctoral thesis but quotes will be given an anonymous participant code. Your identity and that of your health board will remain anonymous in the thesis and any resulting publication. It is intended that the thesis may later be submitted to academic journals for publication and/or for presentation at relevant conferences (again without identifying participants or health boards).



**Who has reviewed the study?**

The research has been reviewed and given a favourable opinion by NHS [name] Research Ethics Committee and [name] Research and Development Department.

**What will happen if I decide I don't want to carry on with the study?**

You are free to withdraw from the study at any time without giving a reason. If you withdraw, your interview data will be destroyed and will not be included in the write-up of the study.

**Who can I contact if I have any questions?**

If you have any questions about any aspect of the study, you can speak to:

**Researcher**

Jessica Hendry  
Trainee Clinical Psychologist  
Contact details

**Field Supervisor**

Name & Contact details

**Further information and contact details:**

If you have any concerns about the study or wish to speak to someone who knows about the research but is not directly involved in the research you can contact:

Dr Sean Harper (Academic Supervisor)

Contact Details: Clinical & Health Psychology, School of Health in Social Science,  
University of Edinburgh, Teviot Place, Edinburgh EH8 9AG  
Telephone: 0131 651 3946

*Thank you for taking the time to read over this information*

# Appendix

## 2

## Interview Guide –Version 2.0

### **Introduction**

The interview today is going to be unstructured, so although I have some general areas I want to cover, I hope the interview will be more like a chat, with you doing most of the talking. I'm interested in finding out about your own experiences and opinions, so there are no right or wrong answers. Sometimes my questions might sound a bit obvious, but it's just to try and find out a bit more about how you see things, so that I'm not making any assumptions. If you want to stop at any point, or if there are any questions you don't want to answer, please just let me know.

### **Introductory Questions**

- What's your job title? (What training involved)
- How long have you worked here? (Previous work places?)
- How long have you been qualified?
- Do you subscribe to any particular theoretical models in your work (e.g. Psychodynamic/family therapy etc).

**1). Could you tell me about a clinical experience (or a couple of experiences) that have had a particular impact on you (which particularly stand out in your mind)?**

*Probes: What were the effects (emotional, personal, professional, behavioural, thinking, feeling etc of these key experiences)*

**2). How did you deal with the experience?**  
(What did you do with that experience?)

**3). How do you feel that therapeutic work has influenced you? (either in your professional development or personally).**

*Probe: Would you say that you have changed in any way? Either a positive or a negative way? Specific examples of how they have been influenced.*

*Probes: Was it lasting? How did it progress? What areas of life did/do the changes extend to (e.g. relationships, self, world view, work with clients etc).*

**4). How has the way you deal with therapeutic work changed over time? (specific examples of change.**

# Appendix

## 3

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## Interview Guide –Version 1.0

### **Introduction**

The interview today is going to be unstructured, so although I have some general areas I want to cover, I hope the interview will be more like a chat, with you doing most of the talking. I'm interested in finding out about your own experiences and opinions, so there are no right or wrong answers. Sometimes my questions might sound a bit obvious, but it's just to try and find out a bit more about how you see things, so that I'm not making any assumptions. If you want to stop at any point, or if there are any questions you don't want to answer, please just let me know.

### **Introductory Questions**

- What's your job title? (What training involved)
- How long have you worked here? (Previous work places?)
- How long have you been qualified?
- Do you subscribe to any particular theoretical models in your work (e.g. Psychodynamic/family therapy etc).

**1). Could you tell me about a clinical experience (or a couple of experiences) that have had a particular impact on you (which particularly stand out in your mind)?**

*Probes: What were the effects (emotional, personal, professional, behavioural, thinking, feeling etc of these key experiences)*

**2). How did you deal with the experience?**

**3). How did that experience impact on your personal and professional development (probe both personal and professional).**

**4). Would you say that the experience changed you in any way? Either a positive or a negative way?**

*Probes: Was it lasting? How did it progress? What areas of life did/do the changes extend to (e.g. relationships, self, world view, work with clients etc). Any changes as a result of the work in general?*

**5). Would you say that you have changed in any way as a result of your work overall?**

**6). Has your way of dealing with these types of experiences changed over time? (over the course of your practice? In what ways? What might you do differently now if faced with the same situation?)**



# Appendix

## 4

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**Participant Consent Form**  
**(22/08/07, version 1.0)**

Study Number: 07/S001/63

Title of Project: **Clinicians' responses to therapeutic work – A qualitative analysis**

Name of Researcher: **Jessica Hendry**

1). I confirm that I have read and understand the information sheet dated 24/09/07 version 2.0, for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

☐

2). I understand that my participation is voluntary and that I am free to withdraw at any time without giving reason.

☐

3). I understand that the interview will be audio-recorded.

☐

4). I understand that (anonymous) verbatim quotes from the interview may be used in the write-up of the research.

☐

5). I agree to take part in the above study.

☐

\_\_\_\_\_  
Name of participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name of researcher

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

*When completed, 1 copy to be given to participant, 1 copy kept for researcher*

# Appendix

## 5

## Appendix 5

### Transcription Notation

The following features were transcribed. A formal system of notation was not used.

- Pauses: Pauses of three seconds or less are indicated by one, two or three dots (corresponding to one, two or three seconds). Pauses of greater than three seconds are indicated as a number in square brackets [5].
- Interviewer speech/sounds: Interviewer's comments or other speech sounds occurring within participant's speech are shown within parentheses e.g. (um  
hmm).
- Emphasis: Emphasis or stress on a word or fragment of text is shown in **bold** type.
- Descriptions of behaviour or non-verbal aspects are shown in square brackets, e.g. [laughs], [smiles].

# Appendix

## 6



25 October 2007

Miss Jessica Hendry  
Clinical Psychologist in Training

Dear Miss Hendry

**Full title of study:** Child & Adolescent Mental Health Care: A qualitative study of clinicians' responses to their work.  
**REC reference number:** 07/S1001/63

Thank you for your letter responding to the Committee's request for further information on the above research and submitting revised documentation.

#### **Confirmation of ethical opinion**

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

#### **Ethical review of research sites**

The favourable opinion applies to the research sites listed on the attached form.

#### **Conditions of approval**

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

A handwritten signature in ink, appearing to be 'J. Smith', written in a cursive style.

## Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Application	5.4	22 August 2007
Investigator CV	1	22 August 2007
Protocol	1	19 August 2007
Covering Letter	1	09 August 2007
Letter from Sponsor	1	20 August 2007
Compensation Arrangements	1	20 July 2007
Interview Schedules/Topic Guides	1	22 August 2007
Participant Information Sheet: PIS	2	24 September 2007
Participant Consent Form: PCF	1	22 August 2007
Response to Request for Further Information		
Supervisors CV	1	17 August 2007
Supervisors CV	1	20 August 2007

## R&D approval

All researchers and research collaborators who will be participating in the research at NHS sites should apply for R&D approval from the relevant care organisation, if they have not yet done so. R&D approval is required, whether or not the study is exempt from SSA. You should advise researchers and local collaborators accordingly.

Guidance on applying for R&D approval is available from  
<http://www.rdforum.nhs.uk/rdform.htm>.

## Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

## After ethical review

Now that you have completed the application process please visit the National Research Ethics Website > After Review

Here you will find links to the following

- a) Providing feedback. You are invited to give your view of the service that you have received from the National Research Ethics Service on the application procedure. If you wish to make your views known please use the feedback form available on the website  
<https://www.nationalres.org.uk/AppForm/Modules/Feedback/EthicalReview.aspx>.
- b) Progress Reports. Please refer to the attached Standard conditions of approval by Research Ethics Committees.
- c) Safety Reports. Please refer to the attached Standard conditions of approval by Research Ethics Committees.



# Appendix

## 7

... from this child to  
 a child → not just what  
 as child had been through  
 is it as if it wakes her up  
 a universal phenomenon →  
 situation that this happens?  
 is some depersonalisation  
 needed to cope & talking  
 about it?)

... that prevented her from  
 understanding it at the time?  
 ... seems to be a critical  
 moment → moving back + forth  
 from then to now

... that how she experiences  
 situation is fluid? The  
 experience of it is tied to  
 something immediate within the  
 surrounding context.  
 Individual perception\*

... understanding has given her  
 different view. Does  
 experience influence the way  
 she emotionally respond to  
 cases?

... 'primal' reaction  
 seems hard to think about.

... was she unprepared for  
 the brutality of what she  
 heard?

... what was blown away?

... was it her protective covering? Was she

blown to pieces / shocked / numb or lost? Taken somewhere new?

piece of work I can recall that made me feel, I think  
 really quite powerfully, powerfully upset, sad, and kind  
 of angry for what a child had been through and lived  
 through (um hmm) and I think also quite a lot of anger  
 that the foster family she was with just shouldn't have  
 been a foster family. And I didn't feel that she was being  
 looked after, I didn't feel that she was being cared for  
 erm and she was a wee girl who brought out the most  
 maternal feelings in I think everyone around her. And  
 for me there was something, I think at the time I didn't  
 understand it in this way but now I think that probably  
 represented the lack of care that she was receiving, the  
 lack of care and the abuse that she, she had received in  
 the past. I think as an early experience, that would be the  
 one that stands out, but I don't know if faced with the  
 same problem now I'd experience it in the same way  
 because I think my understanding has evolved. So I  
 might experience it as something different erm..

E: So kind of looking back, your take on it now is a bit  
 different to how it

003: I think my take on it now is very different and  
 I.. would see that being about understanding.

E: What about at the time, what do you think your  
 experience of it was?

003: Erm, I think my experience was very primal. Is  
 primal the right word to use? I think I had a really sort  
 of primal... reaction to the child, I think really quite..  
 raw reaction to the story ....and probably hearing the  
 story is... I can't remember how I heard the story, what  
 the powerful way was, I think it was another worker  
 sharing the story from the notes. But I remember being  
 absolutely blown away with the details from the case  
 notes and probably the first time that I'd heard anything  
 as awful as that. So I think that's what the primal bit

Powerful feelings  
 experienced - empathy  
 with child.

Uses 'powerfully' to  
 emphasise quality of it

No-one was caring for  
 her.

Emphasis on wee girl  
 + on how she feels rather  
 than thinks  
 Maternal feelings brought  
 out.

Understanding of it has  
 changed with time -  
 making sense of it in  
 present - linking theory in  
 to it?

Experience of it linked  
 to level of understanding.

Evolution of understanding

View has changed

Use of 'seeing' / take on  
 it.

Unsure of how to describe  
 the experience.

Primal reaction

Raw

More hesitation as she  
 goes back into the experience  
 is she tapping into the  
 original emotion?

Powerful

Blown away by details  
 not just emotional but

Hadn't heard anything  
 as awful before.

Exposure to something  
 new and terrible



was about. It was really a new experience for me to hear that young people were so badly badly treated.

I: And would you be able to say a bit about what effect that had on you?

003: I think I kept the wee girl constantly in my mind, sort of in work and out of work. Made even more difficult because she lived not too far from where I stayed at the time, so there was always the chance or opportunity that our paths were going to cross. They actually didn't cross that often. I think I saw her or passed her a couple of times but there was something about the relative closeness of her that personalised it or made it seem, I think, closer to home.

I: When you said you kept her constantly in mind do you mean you kind of tried to consciously or just that she was there?

003: No, just that she was there, she was there almost kind of penetrating my thoughts at times and it wasn't a conscious thing, she would just constantly pop into my mind and again, I think my understanding of it now, at the time I wasn't getting it but this wee girl was just constantly in my thoughts and how she was living, really feeling for her situation was preoccupying my thoughts,

I think now that's about in some way not being held in anyone else's mind, you know that lack of care again.

There was something about what that little girl brought out in me was 'I want to be looked after and cared for' and I think other people who came across her would say similarly. You know other workers would go home, would talk about going home at night and she would stay with them, she was quite searching, she really pulled a lot out of individuals [coughs].

I: What stage was it at when you started working with her? Had the disclosures already been made?

New experience to hear about it.

Didn't know before?

Seems unlikely → something about having to hear it (be witness to it?) is difficult.

She was constantly kept in mind.

Difficulty of proximity out of work.

Expecting or wanting to see her or dreading it?

Closeness to home

Reminded by the girl's physical presence/proximity? Reminded of the reality?

Something about home? → Infiltrating personal life? A need to keep it away from home?

She was there - like a ghostly presence?

Penetrating her thoughts. (sexual metaphor?)

- unwanted penetration

Repetitious thoughts - unexpectedness of 'popping'

Movement between Her + now

Really feeling for her → deep empathy.

Moving back to present understanding. Reflecting upon / processing.

Remember that she's 'little'

Client's ~~reaction~~ acting on therapist - drawing things out of you.

Comparison to other workers - Normalising?

Searching - intrusive?

Emotion? Something 'gulled out'?

↳ Does she react to hide the emotion?

interesting use of 'kept'  
links to idea of secrecy of abuse? Also image of her being kept safe and locked away by being held in mind makes it sound voluntary, which is why I ask the next question

intrusive thoughts → trauma?

popped into her mind  
clockwork/uncontrollable  
leading to it.

pin relates to time factor  
difference between Her and now.

Client like a leech or sponge? → Drawing things out from your depths  
need to respond to the clients need?

switch from talking about her reactions to other people's reactions. Is there a need to distance herself at this point? Is she feeling very emotional or is she trying to normalise her reaction?

Why do I ask this question Lee?

was I uncomfortable with the ↑ emotion in the room?

003: Yeah, the disclosures had been made and she's been placed in foster care and we had her when she had been placed at that point. It was a different set up from here, it was a day unit that I was working in so she was involved with different workers or doing different things and for a good period of time she wasn't at school so her education was provided in the unit as well as her therapeutic treatments and erm, kind of wide ranging day unit therapies. So she was there a lot.

I: And so did you see a lot of her?

003: Yes, she was there 9-3 five days a week.

I: Okay... and erm, how did you deal with the experience do you think?

003: Erm, the how would be about speaking to colleagues, we were quite a tight group of colleagues, so supervision with colleagues would be a huge part of that erm [sighs], but I don't think I dealt with it well at the time, I don't think I dealt with it at all well erm, because I think I allowed it to be in some way to be such a penetrating, you know, penetration into my thoughts, into my daily life. So I don't think I dealt with it particularly well.

I: Um hmm, what were the, if its okay to talk about, were the effects of that being so penetrating? On your life, on you?

003: Erm.. I don't know, God that's quite hard (hmm) erm... I was young, I mean I would only be sort of mid twenties at the time, so my life was quite, in fact, hang on a wee minute! No, that's interesting, good question, I'm trying to think I might even have had a, was I a Mum? I don't know if I was a mum then, so I think I was working with her before I was a mum or around the time I got pregnant so that would er, probably help me understand why that became such a big deal. I can't

Owenship → when we had her

Switch between being in the experience to reflecting on it.

She was there a lot

Does this have an impact? → Duration intensity of contact?

Moves on from practical to emotional → supervision = practical.

Dealing with it

Signs of emotional retreating?

Didn't deal with it at all well - self blame?

Allowed it to penetrate → implication that should/could have stopped it? (Like abuse?)

Repetition of idea of not dealing with it well - as if apologetic? Hail Mary's? Confusion?

Communication to me

Flow of thought changes Thinking it through

Moment of revelation.

Making line corrections

Talking about it seems to be making sense of it for her - Processing taking place?

Thinking about motherhood correction helps understanding

Impact of motherhood

Impact of clinical material  
resonance = ...

business, penetrating thoughts → trauma?

He seems quite critical herself at this point as if she let herself in some way? Frustrated at she "let it" penetrate as if it could have been stopped somehow?

How much of what's experienced a role is taken on board becomes part of us. E.g. Here abuse case her prevailing stage is about penetration allowing something unwanted. ? introjection?

Confusion → sense of her trying to fit different pieces together in her head. In active sense-making process seems to be occurring.

What's the connection  
between being a young mum  
recognising the dangers? Does  
heighten the empathy, the sense  
of honor? Does it make it more  
personal? → Personalises it?

Uses impression this is  
very active and emotive  
- her.

Brings it home more?

Will seem to be  
trying this uncertainty  
rears the worst for her.

Feeling of needing to fill this  
girl up → to put things into  
her + give her something (yet  
this is futile as she can never  
be filled) but also a feeling  
that she is infectious → so a  
need to stay away from her.  
Push and pull → situation  
tension + conflict

Also a feeding  
metaphor; the girl is  
a hungry baby -  
unsatisfiable

remember, it would be around that time....in fact, I'm  
trying to work back dates and details... I would have  
been a young mum at the time, so there's probably  
something about being a young mum and recognising  
the dangers that some kids have to face, which was  
probably why, that helps me understand why it had such  
a huge impact on me [5].

I: And the impact, can you say anymore about what that  
was?

003: I think it was an overwhelming need. A sense that  
the young person had such an overwhelming need and  
almost that need couldn't be and wasn't being met. And  
for me, still feeling to this day that it probably was never  
met. I've no idea what happened to the young girl, but I  
just wouldn't be surprised if she went from one awful  
situation to another. There was just a, it felt as though  
she was a bottomless pit that could never be given  
enough to fill her. She was just so empty and so  
disturbed. I think her disturbance was very infectious  
and I know other workers shared.. I think even though  
I'm finding out in thinking about it, I'm working out  
that my being a young mum was significant, other  
workers who were in different positions, I think were  
equally as affected by her.

I: You said, I think you said, you didn't think you'd  
dealt with it well at that time, or you could have dealt  
with it better?

003: I think my lack of experience, my lack of  
knowledge, my lack of understanding didn't allow me to  
process things in the way I would do now.

I: [5] Okay, can you say anymore about what you mean?

003: I think I couldn't put the pieces together well  
enough and for a kid that had been abused and to some  
extent that answered why there was a disturbed girl

Difficulties recalling

live processing / putting  
pieces together.

Impact of motherhood and  
youth?

Recognition of dangers → cones  
face to face with a dark  
side of life?

huge impact  
A need to understand?

Overwhelming need

Overwhelmed by the  
person's neediness?

Nothing can be done →  
impossible to meet the need  
? Helplessness

Ongoing feeling → to resent  
day

fearing the worst, no  
happy ending. No resolution

Bottomless pit; unable to  
be filled.

Empty / hollow. Feeding.

Infected by her disturbance

Need to bring in effect on  
other workers → move away  
from talking about self. Is

Here a need to distance  
oneself?

Raw working out → sentence  
not finished.

Processing

Inability to process  
things in the same  
way.

Being inexperienced

Putting the pieces together  
- jigsaw puzzle?

Sentences unfinished →  
non sequiturs

Doesn't make sense like  
it didn't make sense to her  
at the time. ? A more bac

from simple sums  
to equations  
↓  
increasing sophistication  
of working out.

that prevented her  
from adding it to the  
equation? She was able  
to see it but couldn't  
work with it / do anything  
useful with it?

the 'processing'  
important for her emotional  
reaction? This is in response  
to you about how she dealt  
with the experience

there. And so there was abuse equals disturbance in my mentality, if you like, or my brain at the time. But er thinking about it now er, I think my understanding of the systems and how the systems that worked around this girl, were so problematic and although I saw that at the time, I don't think I was able to add it into the mathematical equation and I think I would guess to some extent, her foster placement was very damaging for the child. But I couldn't put it into the equation the same way I would now. There were lots of other bits that as workers we didn't know and weren't aware of and maybe things we weren't looking for either. I think my experience of working with people who've been abused and working within those systems now, would make me far more confident, would be aware of even more risky areas, or the importance of getting more information and not just sticking at, where I worked had a very medical behavioural approach to problems in the beginning, so nobody kind of looked for the additional bits. I think now the additional bits are what we go in for now, but at the time it was quite a medical behavioural approach to thinking about problems....

[Pause for few minutes due to tape player beeping]

I: Okay, what I was going to say, it might sound like a strange question and I don't know if you can answer this, but what do you think that experience meant to you at the time?

003: Erm, I think at the time it was a real eye opener and at the time... I think I was exposed to a kind of darkness and a badness that I hadn't considered I would be exposed to. [laughs] Which sounds crazy because on a kind of intellectual level I knew that working with children with mental health problems was going to mean, you know, that I would see, you know, were going to

Hesitations  
→ difficulty actually  
speaking of the  
brutal reality.

A sort of searching  
is taking place

↓  
A need for answers/  
explanations / sense making  
Simplistic understanding  
 $1 + 1 = 2$

Brain v. emotion?

Moving from past to  
present understanding.  
Saw it but couldn't add it  
to the equation.  
Mathematical equation  
needed

Putting bits into the  
equation retrospectively.

Things have changed →  
now is different

Missing parts → didn't know  
where to look.

Systems experience

Greater confidence now  
and greater awareness.

Moving between how things  
done in present + how done  
in past.

Nobody was looking  
Collective shortsightedness  
Reflection on meaning  
of different approaches/  
models in work.

→ or 'I' opener?

Eye opener (to evil)

Emphasis on I → person  
to me self

Darkness / badness  
[Exposure] →  
Laughter → marking an  
newly: wonders what I  
will think?

Intellectual understanding  
versus emotional  
impact.

Reality check?



When we talk about abuse we use terms like 'picture' + 'strong' → gives it a 'fairytale' element of gloss? Is this some way of protecting ourselves from the reality.

come across children with stories of abuse. But there was something about I think, the face-to-face brutality of this girls story that was just so awful. There was something about the level of erm... just something about the level of badness and evilness that she'd had to endure that made being around her really tough. I've forgotten what you asked me again.

I: It was just about what the experience meant to you.

003: Um, hmm, so there was an eye opened to you, you know, this is what a picture of what a child who's been abused can be and not the very superficial picture I maybe had in my mind and my thoughts. You know, I think I maybe had a preconceived idea what an abused child might present like and here, oh my god, this wasn't it! [smiles]. So there was a reality, a reality.

I: And kind of having your eyes opened to that, what was that experience like?

003: I think it scared me. I think it really scared me. It really made me think about the really bad stuff er, part of that preoccupation was 'oh my god, this stuff really goes on out there' and er... oh god, I felt..... I can't even think, even trying to recall the feelings.. at the time I could have gone bla bla bleaugh, because there was just so much. Thinking back, I think just the sadness, the absolute sadness and shock (hmm), about what we were dealing with. But with that, and this is a kind of horrible thing to talk about, but with that there was a bit of an unhealthy buzz I think and maybe that was er, I don't know, maybe something about the neediness.. and something about thinking 'well I've got a job to do here to work with this neediness'. So I think for a small chunk of time there was a compulsion in me to sort something, a compulsion in me to fix something, to make something better, that was probably a pretty

Reality ↔ self protection.  
Stories of abuse → Softening impact / euphemistic term  
Face to face brutality  
↳ being compared with the reality (no protection)

Level of badness + evilness  
Really tough to be around her (a desire to escape?)  
↳ Escapes by forgetting?

Eye opened → sounds painful Against will.  
Picture → euphemism? A child picture  
Superficial picture / naïveté  
Details missing / unthinkable  
↳ defence

Shock?  
Why smiles? → At our naivety  
Reality check  
Repetition of 'really' as if to emphasise it.

Scared → Really scared  
Emphasis / repetition of really (really)

Impact on processing / ability to think + reflect.  
Too awful to think about  
Loss of flow of sentence  
like sickness / diarrhoea?  
Uncontainable / uncontrollable feelings.

Sadness + shock  
Horrible to talk about  
↳ shame?

Unhealthy buzz → recognised at time?

Points still unanswered / hard to work out.

Compulsion to fix / heal / cure?  
"Grandiose" reaction to absolute helplessness / defence against helplessness?

Practical focus on "job to do"

Rescue instinct? ∈

...that she forgets - is this a way of coping w/ or shutting thoughts of the badness and evilness?

...something about this being very visual; not worrying about the abuse but seeing it → very stark. level of detail?

...of references to God. when speaking about the most difficult parts of the experience.

Protect self by only drawing a sketch in head.

...preoccupied by the shock of reality - like a veil has been lifted and she can't take it in.  
cf: Trauma

...that we were dealing with seems quite impersonal way of talking about it. There a need to move between reality + self-protection / defence?

...initial shock + sadness seems to move into a period of compulsive activity - is this an attempt to forget / protect self? Numbness / loss / grief → tasks of mourning.

# Appendix

## 8



**Table1: Summary of super ordinate group themes, showing individual participant's contribution to theme**

Theme	P03	P04	P05	P06	P07	P08	P09	P10
<b>Emotional exchange</b> <i>Putting things into the therapist</i>	<b>YES</b> Getting under the skin Penetration Keeping a child in mind	<b>YES</b> Becoming part of your mental life – positive feelings.	<b>YES</b> Being tuned in to client's feelings – feeling her pain. Blurring of client-therapist distinction	<b>YES</b> Soaking up emotions	<b>YES</b> Having bad stuff put in Soaking up emotions Merging – is it her or is it me?	<b>YES</b> Reaching a client – making a link.	<b>YES</b> Becoming a monster	<b>YES</b> Client within her system
<i>Drawing things out of the therapist</i>	Maternal feelings drawn out	Feeling starving	Feeling worn out	Becoming burnt out	Feeling tired Needing to eat more			Resources drawn out
<i>Exposure</i>	Having an eye opened Children's safety		Awareness of danger		Being vicariously abused			Feeling different to others
<i>Acting in the present</i>	Re-experiencing emotion				Avoidance of imagery			
<b>Responsibility:</b> <i>Holding on and letting go</i>	<b>YES</b> Acting as a lifeline Holding on	<b>YES</b> Unable to switch off	<b>YES</b> Fear of letting client down	<b>YES</b> Permission to let go	<b>YES</b> Holding the client together Not wanting to let her down	<b>YES</b> Holding the client	<b>NO</b>	<b>YES</b> Letting go
<i>Fear of doing the wrong thing</i>	Managing the impossible	Working with uncertainty	Feeling incompetent	Feeling clueless: not knowing the answers	Working with uncertainty – fear of harming	Fear of harming client Self-doubt		Vulnerability of young person Clinical uncertainty – no right way
<i>Shouldering a burden</i>	Becoming a potential parent	Being THE shoulders	Carrying an emotional burden	Being a lone soldier	Pressure to 'fix'	Becoming the 'axis' Burden of trust		Making life/death decisions
<i>Negotiating responsibility</i>		Learning to balance responsibility	Shift in attitudes towards responsibility Pushing oneself – responsibility to team	Re-negotiating responsibility for nurture	Re-negotiating responsibility			Putting limits on responsibility – not No 1.

	P03	P04	P05	P06	P07	P08	P09	P10
<b>Personal/professional tension</b> <i>Emotional me and the rational therapist</i>	YES Touching on humanity	YES Shift from therapist role 'The Big IF's' (self-doubt)	YES Experiencing raw emotions	YES Feelings discordant with professional identity	YES Mother self versus therapist self	YES Using 'oneself' more Becoming emotionally involved	YES Intellectual understanding versus emotional impact	YES Emotional versus rational
<i>Confronting 'other' aspects of self</i>	Boundary changes Experiencing primal self Personal needs	Questioning of boundaries Primitive feelings: Envy towards client Getting a 'high'	Doubts about professional competence Touching upon personal vulnerability Uncomfortable feelings	Feelings discordant with professional identity	Confronting undesirable self 'Perverse' enjoyment	Resurrection of own difficulties	Challenge to helper identity –becoming a monster	Impact on the total person/ whole being
<i>Role reversal: becoming the patient</i>	Sense of 'madness'		Going through an emotional process	Becoming the patient – illness experience	Becoming unwell		Experiencing vulnerability	
<i>Taking work home</i>	Taking work home	Taking work home	Being forced to take work home	Drawing tighter boundaries – avoiding taking work home.	Taking work home Taking home into work	Taking work home – gains in relationships.		Taking work home
<b>Support and supervision</b> <i>Importance of team support</i>	YES Importance of supervision Containment Limitations to supervision	YES Learning to use support	YES Value of supportive team Value of family support	YES Team containment	YES Benefits of supportive team – support through uncertainty Greater confidence in supervision Illness experience	YES Benefits of support and supervision	YES Support of colleagues - affirmation	YES Seeking backup from team A need for relatedness Sharing the anxiety Being understood Feeling burdened
<i>Impact of lack of support</i>			A wish for therapeutic support Supervision needs not met	Impact of team splits Demanding support Organisational culture			Working in isolation	

	P03	P04	P05	P06	P07	P08	P09	P10
Emotional learning and depletion	YES	YES	YES	YES	YES	YES	YES	YES
<i>Getting to know oneself</i>	Confronting own emotions		Understanding own feelings	Awareness of own limits	Self-knowledge and understanding	Self-understanding	Psychological importance of the work	Gaining perspective
<i>Compassion towards self</i>		Being 'good enough'	Self-compassion	Allowing fun	Permission to have fun	Accepting one's failures		Lowering self-expectations
<i>Mastery of emotions</i>	Confidence to confront and survive	Confidence in tricky situations	Confidence in managing own feelings		Dealing with distress	'Catching' oneself – emotional control		Not jumping at 'shadows'
<i>Sense making: knowledge, reflection and space</i>	Processing complex emotions 'Live' sense making	'Live' sense making	A need for space Theoretical understanding of dynamic processes	Being unable to make sense	Filtering out A need for mind space	'Live' sense-making		Processing – giving space to thoughts & feelings
<i>New ways of working</i>	Learning to ask difficult questions	Learning to ask for help Learning how to fail	Professional competence and confidence	Eclecticism Redefining boundaries Collaborative working	Theory fleshed out Learning to accept uncertainty Asking for help	Professional confidence Appreciating unconscious processes Imaginative ways of working – making links	Respect for unconscious processes Becoming playful Valuing the heart connection Spiritual creativity	Gaining tolerance Balancing distance and numbing Going to a deeper level
<i>Self-protection</i>		Counterbalancing	Protective cynicism	Learning to say No Asking for help Need for boundaries	Balancing life Limiting caseload		Change in reading habits Avoidance of socialising	Sense of humour Avoidance of conflict Giving and receiving
<i>Strain and ill-health</i>			Signs of pressure	Benefits of illness experience	Becoming healthier			Signs of pressure

Individual themes								P09	
								Enthusiasm for job	
								Psychological importance of the work – meeting one's needs	
								Desire to be helpful	
								Transformation of failures – intellectual curiosity	
								Transformation of negatives into positives	